

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12973

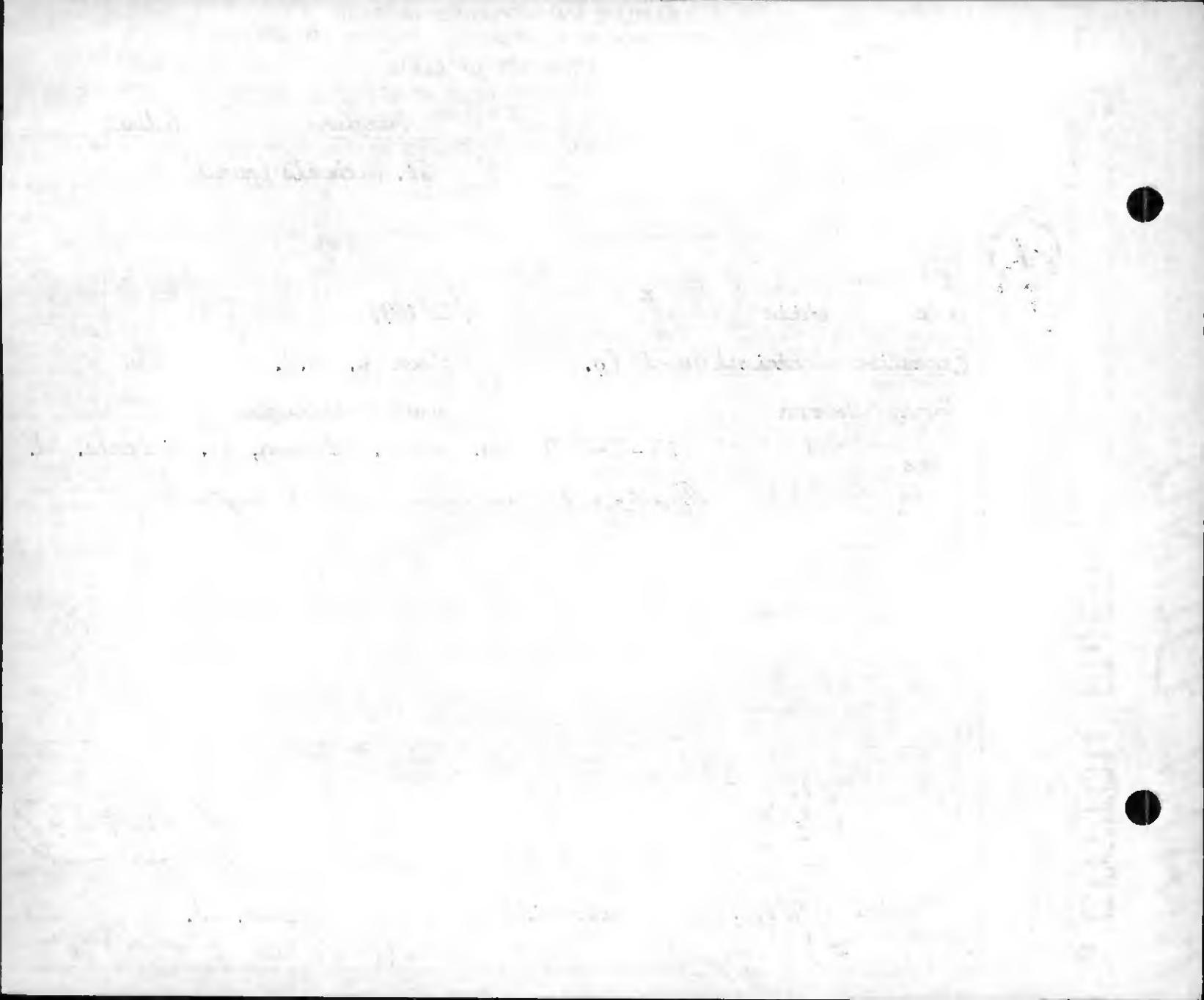
CERTIFICATE OF DEATH

12984

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~so that~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels (rural)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial				d. STREET ADDRESS				
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First John	Middle Alan	Last Ackerman	4. DATE OF DEATH 9 - 16 - 1967	Month 9	Day 16	Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/1899	9. AGE (In years, months, birthday) 68 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive electrical Supply Co.				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Hudson Co. N.J.			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Ackerman				14. MOTHER'S MAIDEN NAME Dorothy Stetzelzle				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 138-22-8404	17. INFORMANT Mrs. John A. Ackerman, St. Michaels, Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				Massive myocardial infarction				
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Easton	(County) Maryland	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) last saw the deceased alive on 13 Nov 1967 and that death occurred at 515 M , from causes and on the date stated above.								
22a. SIGNATURE C. Schmidt				22b. DATE SIGNED 16 Sept 67				
22c. PHYSICIAN'S NAME (Type) E.C.H. Schmidt		22d. ADDRESS Easton, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/19/1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Spring Hill	23d. LOCATION (City or Town) Easton, Md.				
24. FUNERAL DIRECTOR Maurice E. Neumann & Son		ADDRESS EASTON, MD		25a. REC'D BY REGISTRAR SEP 20 1967	25b. REGISTRAR'S SIGNATURE Charles Justice			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

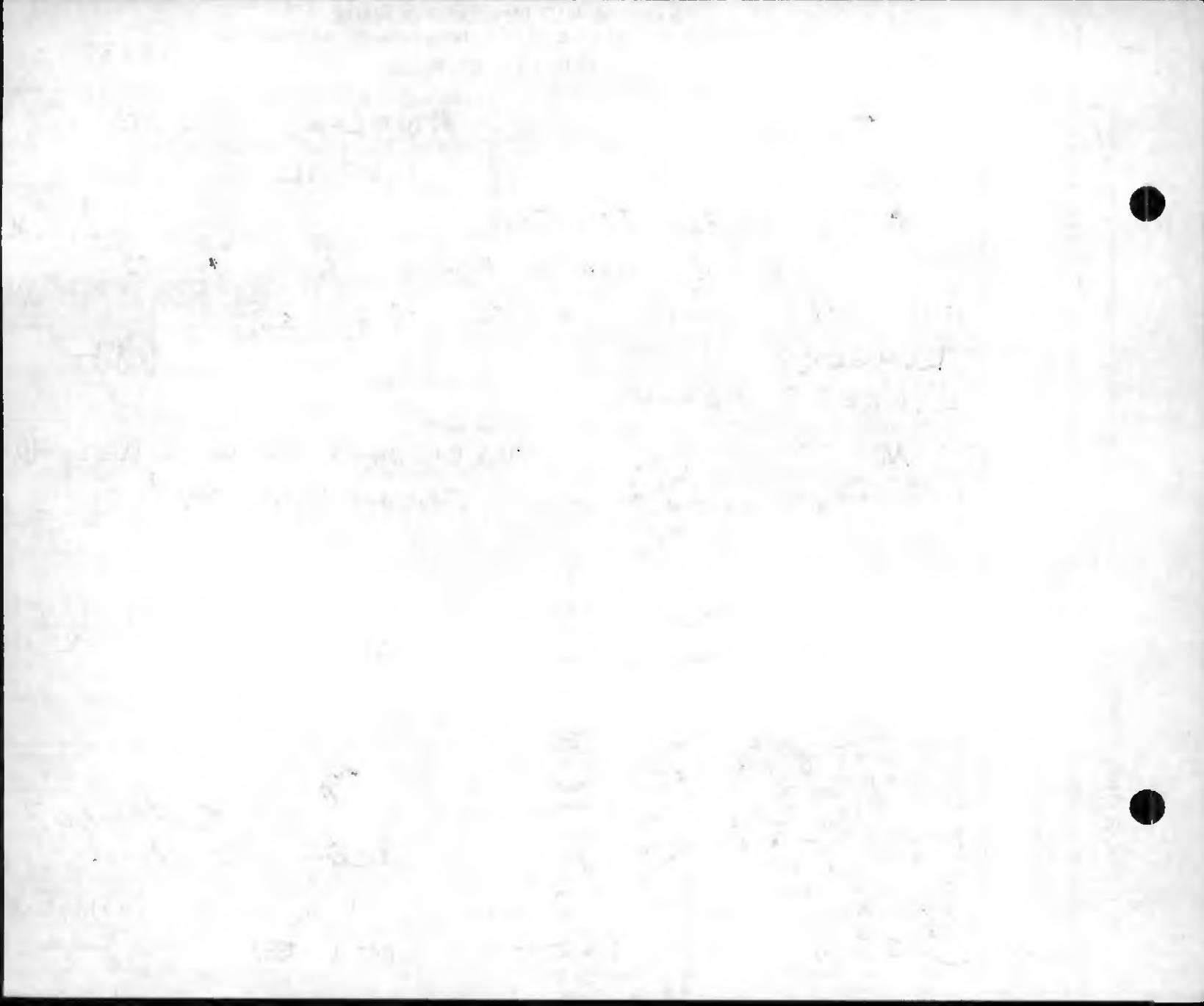
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12980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY CAROLINE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RIDGELY		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First DALLAS	Middle AUSTIN	Last ADKINS	4. DATE OF DEATH Month 9	Month 27	Day 19	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH AUG 18 1910	9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LUMBER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME EVERETT ADKINS		14. MOTHER'S MAIDEN NAME UNKNOWN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. EUGENIA ADKINS, RIDGELY MD.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { (b) DUE TO (c) DUE TO				Sub-acute thyroid hemorrhage, left		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour : o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 940 M, fram causes and on the date stated above.								
22a. SIGNATURE Charles H. Schmidt		M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 27 Sept 67
22c. PHYSICIAN'S NAME (Type) E.C.H. Schmidt		22d. ADDRESS Easton, Maryland						
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF OCT 30, 1967		23c. NAME OF CEMETERY OR CREMATORIAL RIDGELY		23d. LOCATION (City or Town) RIDGELY		(County) (State) MARYLAND
24. FUNERAL DIRECTOR Charles Moore Deardon		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE		
				DATE OCT 4 1967				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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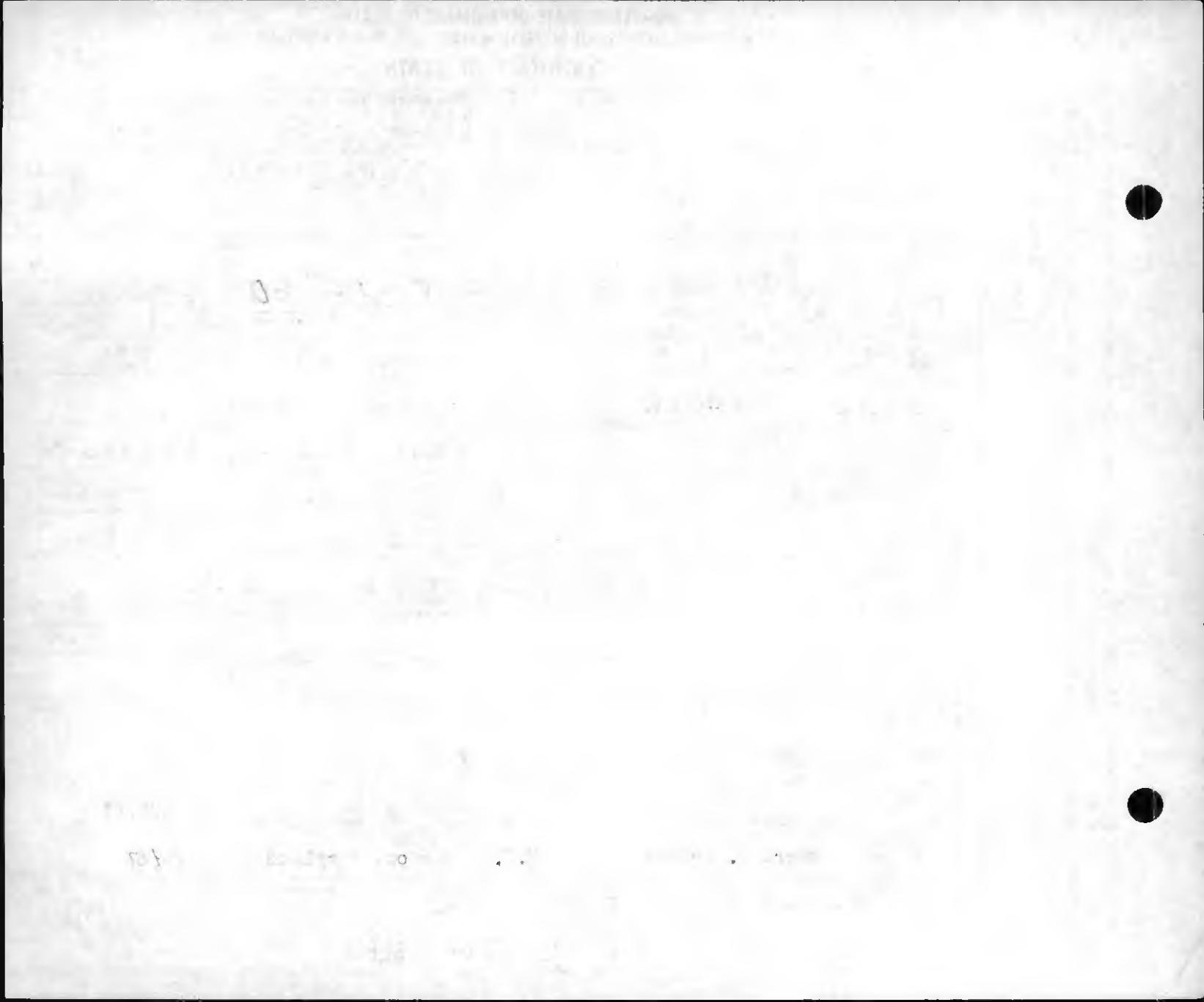
CERTIFICATE OF DEATH

12986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **Log 1 and 2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DELBON AVE		b. COUNTY BENT							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN lb 13 1/2 hrs.		c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) BURRSVILLE		d. STREET ADDRESS 46-3							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
78 3. NAME OF DECEASED (Type or print)		First Katherine	Middle Harriett	Last Baker	4. DATE OF DEATH 9-26-1967	Month 9	Day 8	Year 1967					
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Feb. 15, 1906	9. AGE years 60	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. Father's Name John SINGER	14. Mother's Maiden Name LIBBY MURPHY	Address PAUL SINGER DENTON MD.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH (inactive) uncertain					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-7 , 19 67 , to 9-8 , 19 67 , that (I) (we) last saw the deceased alive on 9-8 , 19 67 , and that death occurred at 2:55 AM , from causes and on the date stated above.		22a. SIGNATURE Robert W. Trever		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/8/67			
22c. PHYSICIAN'S NAME (Type) Robert W. Trever		M.D.		22d. ADDRESS Easton, Maryland		23a. DATE THEREOF SEPT. 10, 1967		23c. NAME OF CEMETERY OR CREMATORIAL DENTON		23d. LOCATION (City or Town) (County) (State) DENTON			
24. FUNERAL DIRECTOR CHARLES V. MOORE DENTON		ADDRESS		25a. REC'D BY REGISTRAR SEP 14 1967		25b. REGISTRAR'S SIGNATURE John C. Moore MD							
VR A15 (4) 25M 1/67													



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm S may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12987

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton LENGTH OF STAY IN lb 3 months		b. COUNTY Talbot	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		d. STREET ADDRESS II9 S. Hanson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) II9 S. Hanson		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Delores		First Bostic	Middle Sept. 28 1967
S. SEX F	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-3- 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years Inst birthday) yrs. 3
13. FATHER'S NAME Mack Dawson		11. BIRTHPLACE (State or foreign country) Florida	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mildred Mitchell
			Address Easton, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leprosis 501X		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Laryngotracheo /moniditis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Easton
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Lewis Phitty</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 9-24-67
EXAMINER'S NAME (Type) V. VELTI		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	Address (Street, city, town, or county)
23a. BURIAL, CREMATION, REMAINS (Identify) burial		23b. DATE THEREOF 9-29- 1967	23c. NAME OF CEMETERY OR CREMATORIAL Richards
23d. LOCATION (City or Town) Easton		(County) Talbot	(State) Md.
24. FUNERAL DIRECTOR B.L. Dashiell		ADDRESS Easton, Md.	25a. REC'D BY REGISTRAR OCT 2 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

10/12/69

10/12/69

adams - spicer

spicer

johnson

johnson

allen

allen

allen

allen

allen

allen

allen

allen

allen - taylor - taylor

allen

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1288

CERTIFICATE OF DEATH

12988

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CO-FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Talbot		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neavitt		b. COUNTY Talbot	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neavitt	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) MARY JANE BRIDGES		First	Middle
4. DATE OF DEATH September 2, 1967		Last	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 23, 1893
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 73 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Talbot County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levin Fisher		14. MOTHER'S MAIDEN NAME Frances Hill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give rank and dates of service)		16. SOCIAL SECURITY NO. 214-32-7095-B	
17. INFORMANT		Address	
No	Weldon Bridges, Neavitt, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
Myocardial infarction atherosclerotic cardio vas.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension Ex Vas.		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1953
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1953 to 9-2-67, 1967, that (I) (we) last saw the deceased alive on 9-2-67, 1967, and that death occurred at 1384 M, from the causes and on the date stated above.		22b. DATE SIGNED 9-5-67	
22a. SIGNATURE Guy M. Reeser, Jr., M.D. M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS St. Michaels, Maryland
22c. PHYSICIAN'S NAME (Type) GUY M. REESER, JR., M. D.			

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VR A15
20M 5-6

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

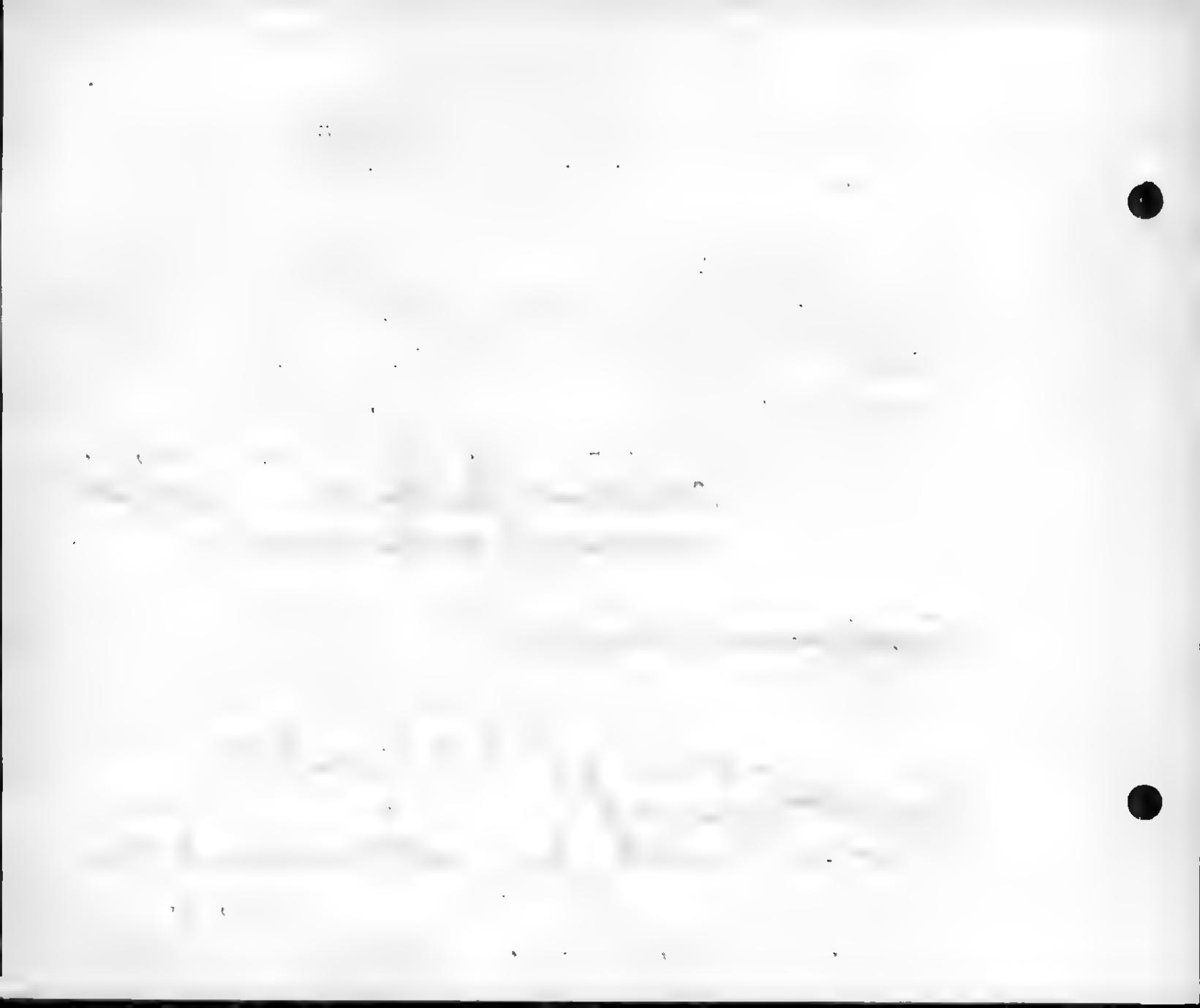
12989

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remble carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

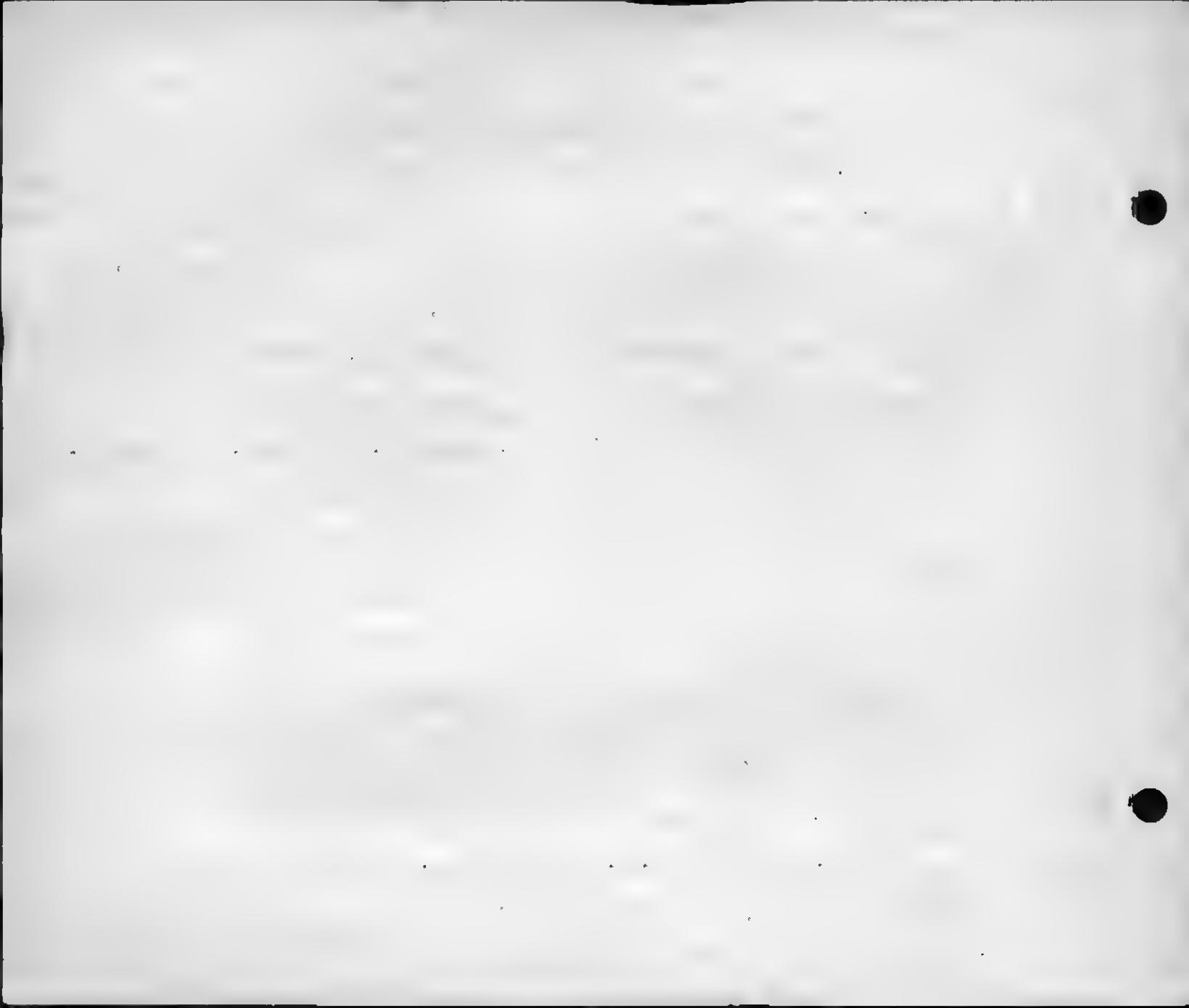
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tilghman</i>		c. LENGTH OF STAY IN 1b <i>Lifetime</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tilghman</i>		d. STREET ADDRESS <i>21</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Andrew Cummings</i>		First	Middle	Last	4. DATE OF DEATH <i>9/30 1967</i>	Month	Day	Year
S. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/15/1891</i>	9. AGE (In years last birthday) <i>76 yrs</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Henry Cummings</i>		14. MOTHER'S MAIDEN NAME <i>Laura V. Birmingham</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-05-8360</i>		17. INFORMANT <i>Mrs. Andrew Cummings, Tilghman, Md.</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardiac failure months</i>		DUE TO <i>coronary & cardiac vasod.</i>		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last		(b) DUE TO						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Emphysema - severe</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>9-30 1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>9-30-67</i> 19 <i>67</i> to <i>9-30</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9-30</i> 19 <i>67</i> and that death occurred <i>9-30</i> AM, from causes and on the date stated above						22b. DATE SIGNED <i>10-2-67</i>		
22c. SIGNATURE <i>Hugh M. Reeser Jr.</i>		M.D. ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		
NAME PHYSICIAN'S NAME & TITLE <i>Hugh M. Reeser Jr.</i>		22d. ADDRESS <i>St. Michael's Med.</i>						
23a. BURIAL, CREMATION, REMOVAL, ETC. <i>burial</i>		23b. DATE THEREOF <i>10/3/1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Pilgrim Holiness</i>		23d. LOCATION (City or Town) <i>Tilghman, Md.</i>		(County) (State)
24. FUNERAL DIRECTOR <i>MURICE E. NEUNAM & SON, Easton, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>OCT 3 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 25M 1/67								



HOSPITAL **ATTENDING PHYSICIAN:** This certificate must be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12980 12390											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
Talbot MARYLAND				a. STATE Maryland b. COUNTY Talbot							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels 2 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDaniel,							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rio Vista Nursing Home				d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print) WILLIAM HASTING DERBYSHIRE				4. DATE OF DEATH September 11, 1967							
First Middle Last				Month Day Year							
SEX Male				8. DATE OF BIRTH Aug 22, 1895							
6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Purchasing Agent				10b. KIND OF BUSINESS OR INDUSTRY Engineering 11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pennsylvania 12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry Edwin Derbyshire				14. MOTHER'S MAIDEN NAME Laura Melville Smith Address							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes WWI 185-03-0751 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Kathryn K. Derbyshire, McDaniel, Md.				INTERVAL BETWEEN ONSET AND DEATH 7 mos - 10 mos							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				<p>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Osteomylitis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (a) } (b) <i>Urinary of Kidney</i> DUE TO (c)</p>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Vallotage Fracture Rib</i>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19				20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21 I certify that (I) (his hospital) attended the deceased from 1967 to Sept 11, 1967, that (I) (we) last saw the deceased alive on 1967 and that death occurred at 3:57 P.M. from the causes and on the date stated above.				22b. DATE SIGNED 9/22/67							
22a. SIGNATURE <i>R. Lane Wroth</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS							
22c. PHYSICIAN'S NAME (Type) R. LANE WROTH, M. D.				St. Michaels, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept 14, 1967 23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery							
23d. LOCATION (City, town or county) Easton, Maryland (State)				23e. REG'D BY REGISTRAR <input type="checkbox"/> 25b. REGISTRAR'S SIGNATURE							
24 FUNERAL DIRECTOR'S SIGNATURE <i>Bardeen & Leonard, St. Michaels, Md.</i>				ADDRESS DATE SEP 18 1967 <i>Charles Judge</i>							



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

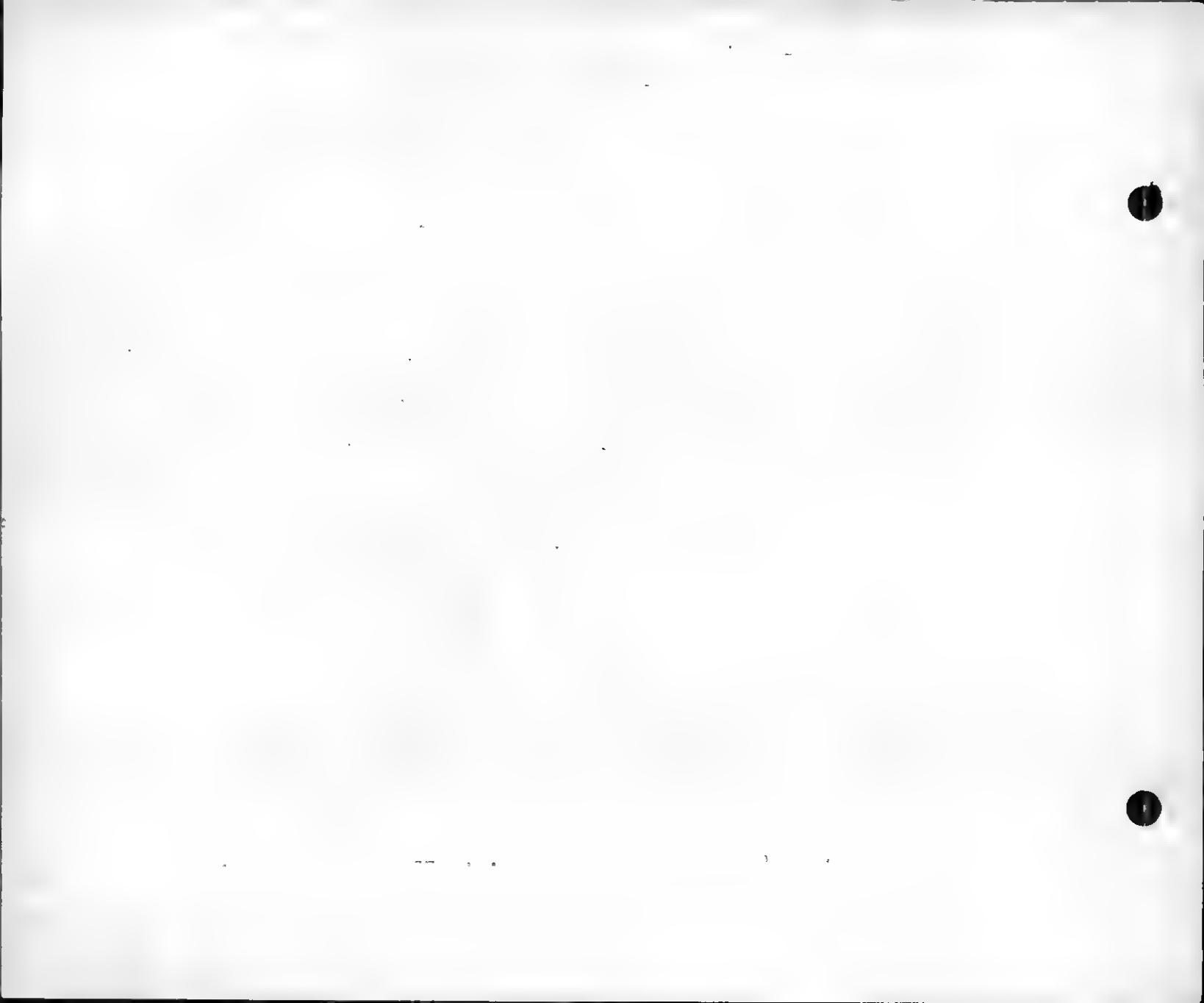
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

12991

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY TALBOT 1986 MARYLAND		2. USUAL RESIDENCE (Where deceased resided, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 45 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial		e. STREET ADDRESS GRACE ST.	
3. NAME OF DECEASED (Type or print) ERNEST M. Dyott		First	Middle
		Last	4. DATE OF DEATH Dyott 9-17 1967
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 31, 1890
9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR <input type="checkbox"/> Months 0	11. IF UNDER 24 HRS <input type="checkbox"/> Days 0	12. IF UNDER 24 HRS <input type="checkbox"/> Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (County & State, or foreign country) St. Michaels		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME JAMES A. Dyott		14. MOTHER'S MAIDEN NAME MARY WILLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWI		16. SOCIAL SECURITY NO 212-16-9654	17. INFORMANT Ernest Dyott, St. Michaels Md
18. ADDRESS		19. INTERVAL BETWEEN ONSET AND DEATH 2 min	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virginia DUE TO Chronic Pyloric Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) 14P. stating the underlying cause (c) last.			
20. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1967
20f. (City or town) St. Michaels (County) Maryland (State) 1967		21. I certify that (I) (this hospital) attended the deceased from 1967 , to 1967 , that (I) (we) last saw the deceased alive on 1967 , and that death occurred at 1967 , M, from causes and on the date stated above.	
22a. SIGNATURE R. Lane Wroth		22b. DATE SIGNED 9/18/67	
22c. PHYSICIAN'S NAME (Type) R. Lane Wroth		22d. ADDRESS St. Michaels, Maryland	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial Sept 19, 1967		23b. DATE THEREOF 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Olivet Cemetery		23d. LOCATION (City or Town) St. Michaels, Maryland (County) Maryland (State)	
24. FUNERAL DIRECTOR Garrison E. Leonard, St. Michaels, Md		25a. ADDRESS 1967	25b. REC'D BY REGISTRAR SEP 21 1967
		25c. DATE 1967	25d. REGISTRAR'S SIGNATURE Jameson J. Leonard





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12989

CERTIFICATE OF DEATH

12993

TO HOSPITAL [] **ATTENDING PHYSICIAN** [] **REAINED** by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. ages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death. Page _____.

(M)

1. PLACE OF DEATH
a. COUNTY

Talbot

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Easton

c. LENGTH OF STAY IN lb
1MO-9 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

HOUSE IN THE PINES-EASTON, MD.

3. NAME OF
DECEASED
(Type or print)

Margaret

B.

HENNEY

d. STREET ADDRESS

4. DATE
OF
DEATH

September 28

1967

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

Dec. 18-86

10a. JSLAL OCCUPATION (Give kind of work done during most of working life, even if retired)

OrthoAI Nurse

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Phila., Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Olef Schroeder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

1750

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

16. SOCIAL SECURITY NO. 17. INFORMANT

431-20-0054 Lt. Col. Martin Schneider

Dorothea Meyer
Address 4750 Kenmore Ave.
Arlington, VA.INTERVAL BETWEEN
ONSET AND DEATH
→ 6 wks.

Carcinomatosis

Metastatic adenocarcinoma
of the ovary

→ 6 wks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m.20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 19....., to 19....., that (I) (we) last
saw the deceased alive on 19....., and that death occurred at 2:30 A.M. from the causes and on the date stated above.

22e. SIGNATURE

Robert W. Trever

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF
9/30/1967

23c. NAME OF CEMETERY OR CREMATORIAL

LAKEVIEW MEMORIAL PARK MERCHANTVILLE, N.J.

23d. LOCATION (City, town or county)

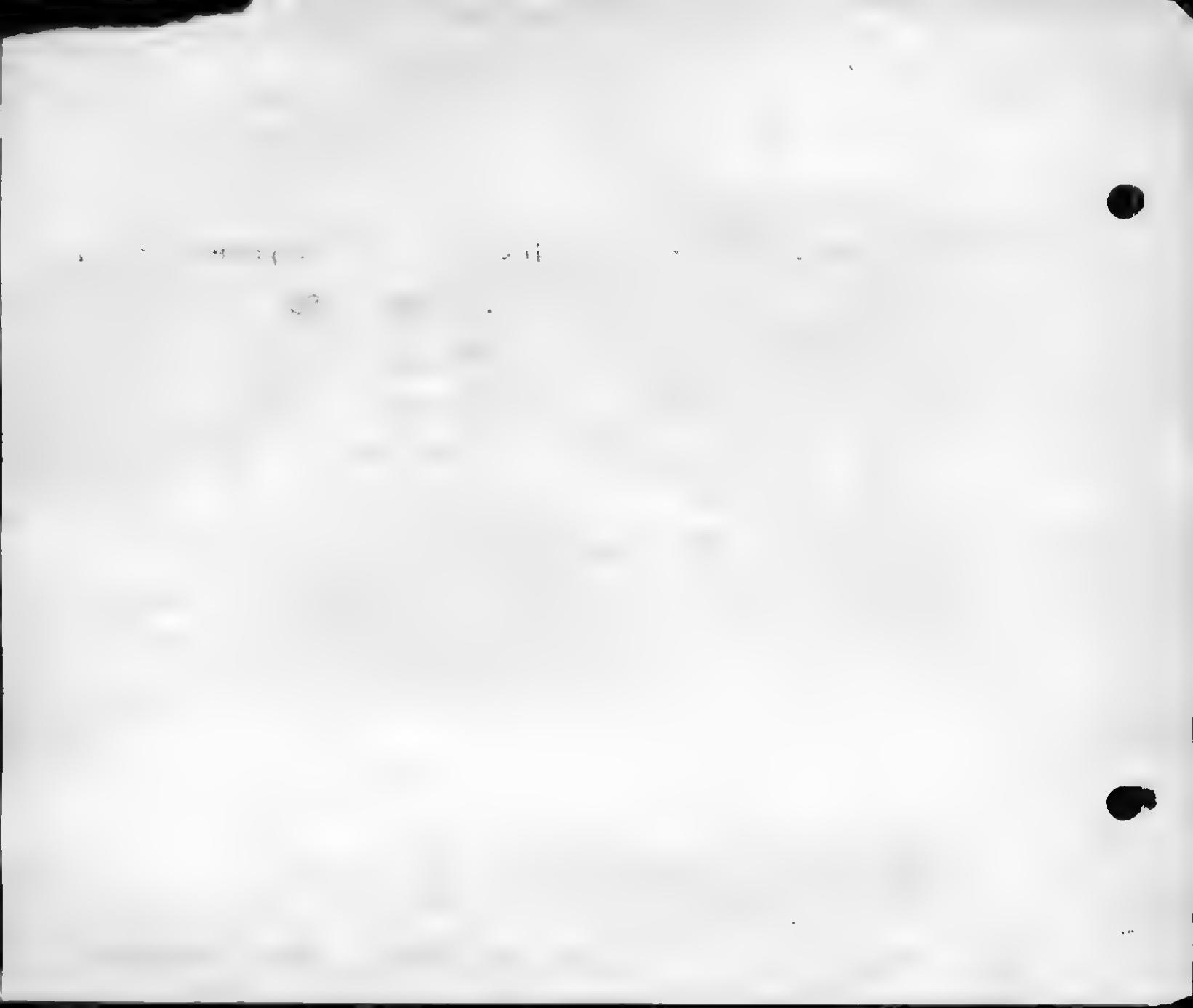
(State)

24e. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS
Maurice E. Neumann-Son EASTON, Md.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

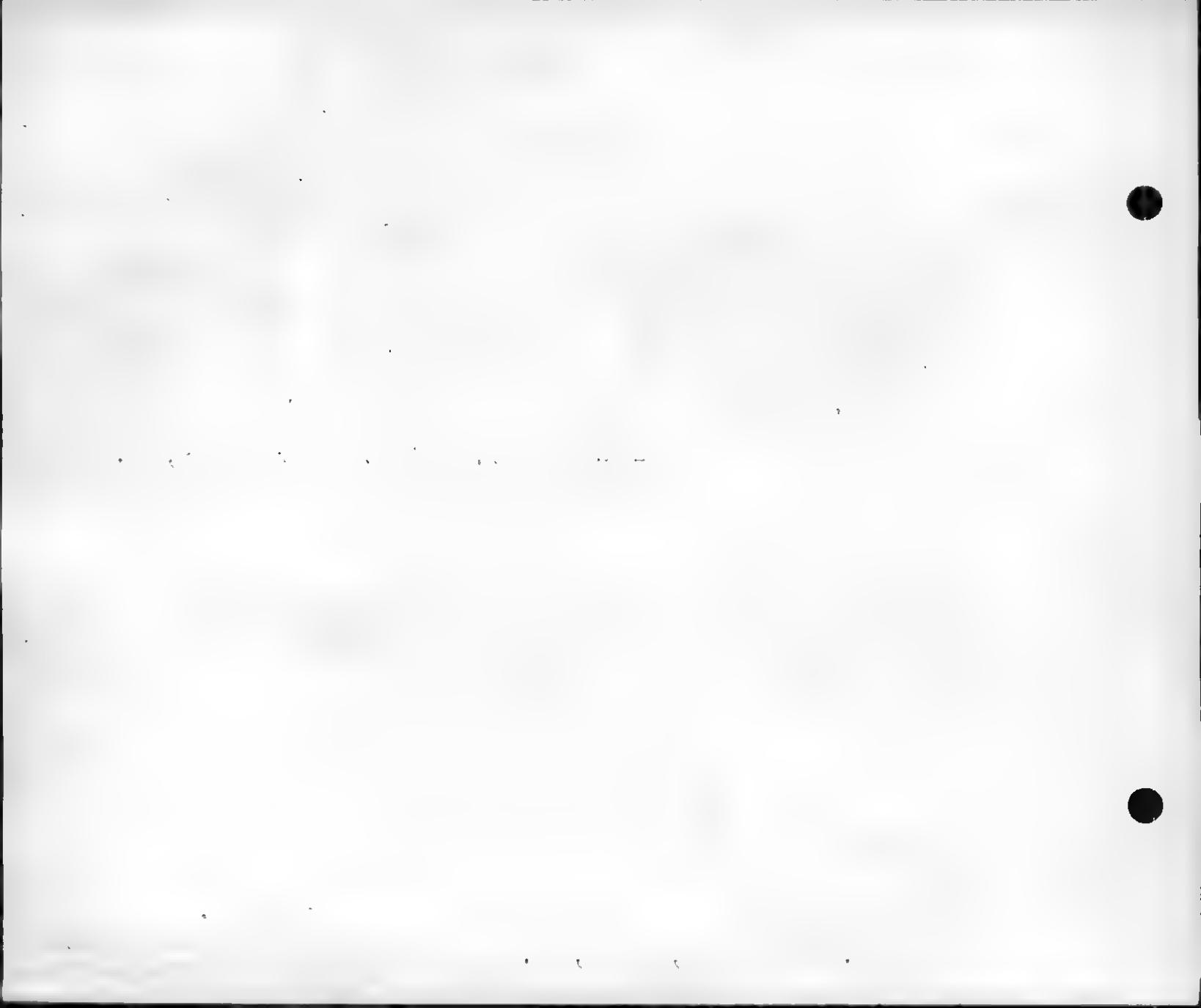
DATE OCT 3 1967 Charles Judge



TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

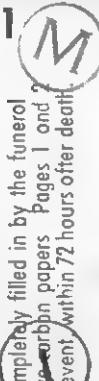
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12983 Item #2b,c & d film #393 10/11/67 ph CERTIFICATE OF DEATH										12994		
1. PLACE OF DEATH a. COUNTY Talbot MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					b. COUNTY Talbot/ Talbot.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford (rural)			c. LENGTH OF STAY IN lb 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford (rural) Talbot. 21201			d. STREET ADDRESS 5316 Gwynn Oak Ave. Sailor's Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sailor's Retreat					d. DATE DEATH 9/21 1967							
3. NAME OF DECEASED (Type or print) Edwin Eugene Hooper		First	Middle	Last	4. DATE Month	Day	Year					
5. SEX male		6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/1884	9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min		
10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Pro. Baseball player & Coach			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland	12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Samuel H. Hooper					14. MOTHER'S MAIDEN NAME Adeline Kershaw							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO 215-50-2939			17. INFORMANT Mrs. Edwin E. Hooper, Oxford, Md.			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia.										INTERVAL BETWEEN ONSET AND DEATH 2 wks.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c) DUE TO												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsonism.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from June 1967 to September 1967 , that (I) (we) last saw the deceased alive on September 1967 , and that death occurred at 5:30 P.M. from causes and on the date stated above.												
22a. SIGNATURE Ronald M. McDonald, M.D.			M.D.		ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/20/67				
22c. PHYSICIAN'S NAME (Type) R. M. McDonald, M.D.			22d. ADDRESS 25 Hanson St. EASTON, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/25/1967		23c. NAME OF CEMETERY OR CREMATORIAL Oxford			23d. LOCATION (City or Town) Oxford, Md.				(County) (State)	
24. FUNERAL DIRECTOR Maurice E. Neumann & Son, EASTON, Md.					ADDRESS			25a. REC'D BY REGISTRAR DATE SEP 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12995

1 PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN TB 24 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS SQ GOLDSBOROUGH ST.					
3. NAME OF DECEASED (Type or print)		First ESTHER	Middle Virginia	Last Hoxter	4. DATE OF DEATH Month 9	Day 6	Year 1967
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH 12-2-93	9. AGE (In years last birthday) 73	10. IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY xx		11. BIRTHPLACE (County & State, or foreign country) Q.A.C. MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME B.L. THOMAS		14. MOTHER'S MAIDEN NAME GEORGIA A. Lewis		Address 216-10-3570 T.O. HOXTER, SEAFORD, DELAWARE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-3570		17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diffuse interstitial fibrosis of X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO	
						the lungs INTERVAL BETWEEN ONSET AND DEATH Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 9:55 AM , from causes and on the date stated above.		22a. SIGNATURE Robert W. Trever		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS		22b. DATE SIGNED 9/6/67	
22c. PHYSICIAN'S NAME (Type) Robert W. Trever		22d. ADDRESS Easton, Maryland				22e. (County) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT 10		23c. NAME OF CEMETERY OR CREMATORIAL STEVENSVILLE		23d. LOCATION (City or Town) STEVENSVILLE MD.	
24. FUNERAL DIRECTOR Edgar L. Lane Church Hill Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 11 1967		25b. REGISTRAR'S SIGNATURE Charles Juge	
VR A15 (4) 25M 1/67							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12991

12996

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Talbot</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels Funeral</i>		c LENGTH OF STAY IN 1b <i>5 years</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rio Vista Nursing Home</i>		e 5 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Harold Francis Hutchinson, Sr.</i>		First	Middle
S SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED WIDOWED <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8 DATE OF BIRTH <i>1/1/1882</i>		9 AGE (In years last birthday) <i>85 yrs.</i>	10 IF UNDER 1 YEAR Months <i>0</i>
10b USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Dairy Dept. Borden Co.</i>		10c KIND OF BUSINESS OR INDUSTRY <i></i>	11 BIRTHPLACE (County & State, or foreign country) <i>Kings N.Y.</i>
13 FATHER'S NAME <i>John Hutchinson</i>		14 MOTHER'S MAIDEN NAME <i>Catherine Wilson</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16 SOCIAL SECURITY NO <i>067-05-5299</i>	17 INFORMANT <i>Harold F. Hutchinson, Jr. Bellevue, Md.</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		19 INTERVAL BETWEEN ONSET AND DEATH <i>3-4 mos</i>	
(b) DUE TO Alth. cardio + embolus void		(c)	
20b ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <i>cachexia, advanced senile changes</i>	
20d TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20e INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20f PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>1961</i> , <i>1965</i> , to <i>9-25</i> , <i>1967</i> that (I) (we) last saw the deceased alive on <i>9-25 1967</i> , and that death occurred <i>9-25 1967</i> M, from causes and on the date stated above		22b DATE SIGNED <i>9-26-67</i>	
22c PHYSICIAN'S NAME (Type) <i>Henry M. Reeser Jr.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d ADDRESS <i>St. Michaels Md</i>
23a BURIAL, CREMATION, BURIAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>9/29/1967</i>	23c NAME OF CEMETERY OR CREMATORY <i>Woodlawn Memorial Park</i>
24. FUNERAL DIRECTOR <i>MURGE E. NEWHAM & SON, Easton, Md.</i>		25a ADDRESS <i></i>	25b REC'D BY REGISTRAR DATE <i>SEP 27 1967</i>
			REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12992

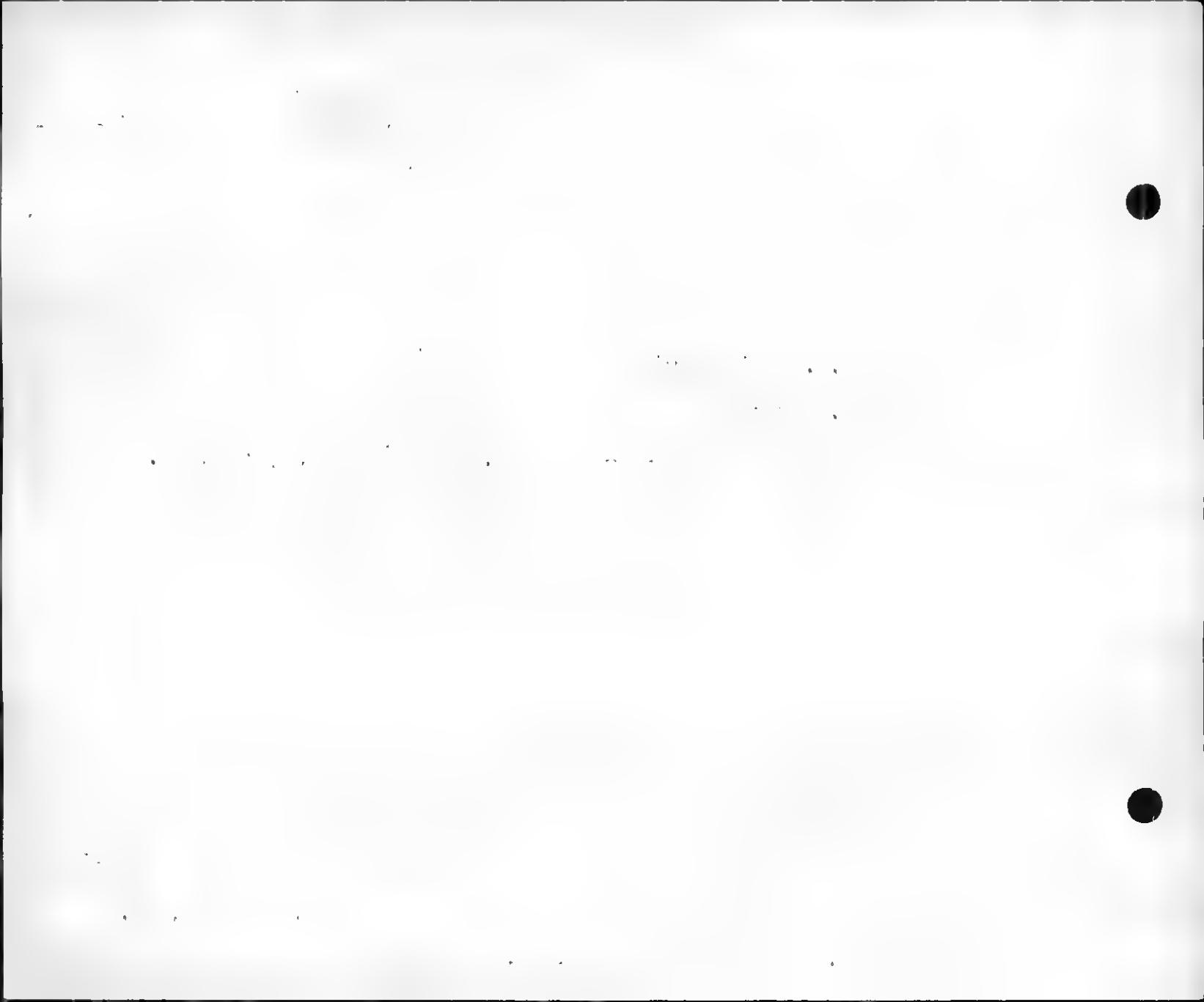
12997

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (With Maryland if institution. Residence before admission) a. STATE	
<i>Talbot</i> MARYLAND		<i>Maryland</i> <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN b <i>7b</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>MEMORIAL HOSPITAL</i>		d. STREET ADDRESS <i>Tilghman</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>WILLIAM</i>	Middle <i>JAMES</i>	Last <i>Jackson</i>
4. DATE OF DEATH	Month <i>9</i>	Day <i>10</i>	Year <i>1967</i>
5. SEX	6. COLOR OR RACE <i>M</i> <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>8/21/89</i>
9. AGE (In years lost birthday) yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer E.S. Public Service</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (County & State or foreign country) <i>Talbot</i></i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>William H. Jackson</i>	14. MOTHER'S MAIDEN NAME <i>Margaret Ann Cooper</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO <i>212-09-4656</i>	17. INFORMANT <i>Mrs. Fred Eberhard, Easton, Md.</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Heart failure</i>			INTERVAL BETWEEN ONSET AND DEATH
4 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <i>(b) Myocardial hypertrophy</i> <i>(c) Gangrene left leg</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) this hospital attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased at <i>Easton Hospital</i> 19_____, and that death occurred at <i>Easton</i> , Md., from causes and on the date stated above.	22b. DATE SIGNED <i>11 Sep 1967</i>		
22a. SIGNATURE <i>Alfred H. Schmidt</i>	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>E. L. H. Schmidt</i>	22d. ADDRESS <i>Easton, Maryland</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>9/13/1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Olivet</i>	23d. LOCATION (City or Town) (County) (State) <i>St. Michaels, Md.</i>
24. FUNERAL DIRECTOR <i>MURICE E. NEUNAM & SON, Easton, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 25M 1/67	DATE SEP 13 1967		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12998

12936

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

DO NOT USE ATTENDING PHYSICIAN: The law requires that Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN b 3 days 9 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		d. STREET ADDRESS 215 N. Locust St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print)	First ERIC	Middle 	Last MATZEIT
4. DATE OF DEATH Sept. 2 1967	Month Sept.	Day 2	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-10
9. AGE (In years last birthday) 56 yrs	10. KIND OF BUSINESS OR INDUSTRY barber	11. BIRTHPLACE (County & State, or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Heinrich Matzeit	14. MOTHER'S MAIDEN NAME Lena		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 214-01-8149	17. INFORMANT Mrs. Mary A. Matzeit Easton, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Colon		INTERVAL BETWEEN ONSET AND DEATH 1 YR	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION	20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town) 	(County)
		(State) 	
21. I certify that (I) (this hospital) attended the deceased from 8-3 1967 to 9-2 1967 that (I) (we) last saw the deceased alive on 9-7 1967 , and that death occurred at 8:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Harry M. Walsh, M.D.		22b. DATE SIGNED 9-8-67	
22c. PHYSICIAN'S NAME (Type) Harry M. Walsh, M.D.	ATTENDING PHYS M.D.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/4/67	23c. NAME OF CEMETERY OR CREMATORIAL Springhill
23d. LOCATION (City or Town) Easton, Talbot, Md.		(County) 	(State)
24. FUNERAL DIRECTOR Jay D. Howard		ADDRESS Easton, Md.	25a. REC'D BY REGISTRAR Charles J. Judge
			25b. REGISTRAR'S SIGNATURE
			DATE SEP 11 1967



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

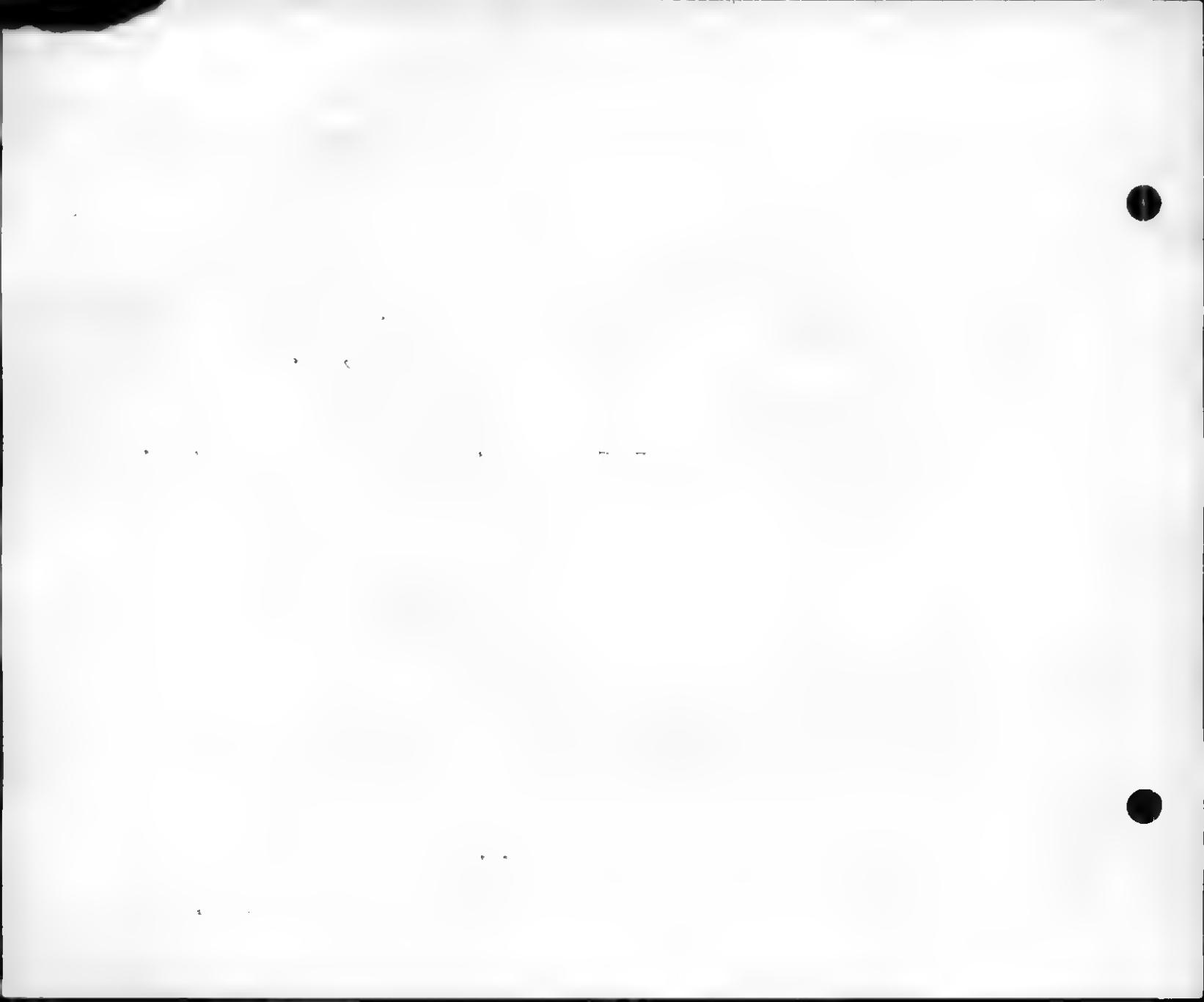
12995

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the State Dept. of Health prior to burial, cremation, or removal, and it may be filed with the State Dept. of Health.

1 PLACE OF DEATH a. COUNTY <i>Talbot</i>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 16 <i>13 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial</i>		e. STREET ADDRESS <i>Box 14</i>	
3 NAME OF DECEASED (Type or print) <i>Gustav</i>		First <i>G</i>	Middle <i>ustav</i>
4 SEX <i>Male</i>	5 COLOR OR RACE <i>white</i>	6 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7 DATE OF DEATH <i>March 16, 1893</i>
8 AGE (In years at birthday) <i>74 yrs</i>	9 IF UNDER 1 YEAR Months <i>0</i>	10 IF UNDER 24 HRS Days <i>0</i>	11 Year <i>1967</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <i>St. Louis, Mo.</i>		12 CITIZEN OF WHAT COUNTRY <i>USA</i>	
13 FATHER'S NAME <i>Maximilian Mende</i>		14 MOTHER'S MAIDEN NAME <i>Helene Nette</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO <i>217-36-1426</i>	
17 INFORMANT <i>Mrs. Gustav Mende, Cordova, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>HEPATIC FAILURE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 DAYS</i>	
199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>CA. COLON + L KIDNEY WITH</i> (c) <i>HEPATIC + PULMONARY METASTASES</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d INJRY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Easton</i>
20f (Cty or town) <i>Easton</i>		(County) <i>Wicomico</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>8 - 25, 1967</i> to <i>1967</i> , that (I) (we) last saw the deceased alive on <i>9-2 1967</i> , and that death occurred at <i>11 AM</i> , from causes and on the date stated above			
22a SIGNATURE <i>JL/KH Hansen</i>		22b DATE SIGNED <i>9/5/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>John Knud-Hansen</i>		M.D. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>Woodlawn Memorial Park</i>
23a BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>9/5/1967</i>	23d. LOCATION (City or Town) <i>Easton, Md.</i>
24. FUNERAL DIRECTOR		ADDRESS <i>Maurice Newman & Son Easton Md.</i>	25a REC'D BY REGISTRAR DATE <i>SEP 7 1967</i>
			25b REG STRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																					
CERTIFICATE OF DEATH																					
12846		43001																			
1. PLACE OF DEATH a. COUNTY		Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural - St. Michaels		4 yrs		a. STATE		Maryland													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Rio Vista Nursing Home				b. COUNTY		Talbot													
3. NAME OF DECEASED (Type or print)		First CLARA		Middle FRANKM		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)													
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		d. STREET ADDRESS													
Female		White		WIDOWED		September 21, 1879		88 yrs.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		9. AGE (In years last birthday)		12. CITIZEN OF WHAT COUNTRY?													
Housewife		---		Harrisburg, Pennsylvania		Months Days Hours Min.		USA													
13. FATHER'S NAME		Edward F. Franken		14. MOTHER'S MAIDEN NAME		Sarah Ann Spousler		Address													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service)		No		16. SOCIAL SECURITY NO.		17. INFORMANT		Records - Rio Vista Nursing Home													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH		2nd													
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Cerebral Hemorrhage		Arteriosclerosis Cardiovacular 10 yrs.													
				(c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19								20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (This hospital) attended the deceased from 6-23 1958 to 9-20 1967, that (I) (we) last saw the deceased alive on 9-19 1967, and that death occurred at 5:15 P.M. from the causes and on the date stated above.		22a. SIGNATURE R. Lane Wroth		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-21-67									
22c. PHYSICIAN'S NAME (Type) R. Lane Wroth, M. D.		22d. ADDRESS St. Michaels, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 23, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Olivet Cemetery		23d. LOCATION (City, town or county) St. Michaels, Maryland		(State)													
24. FUNERAL DIRECTOR'S SIGNATURE Harrison E. Leonard, St. Michaels, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 26 1967		25b. REGISTRAR'S SIGNATURE in my office															



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

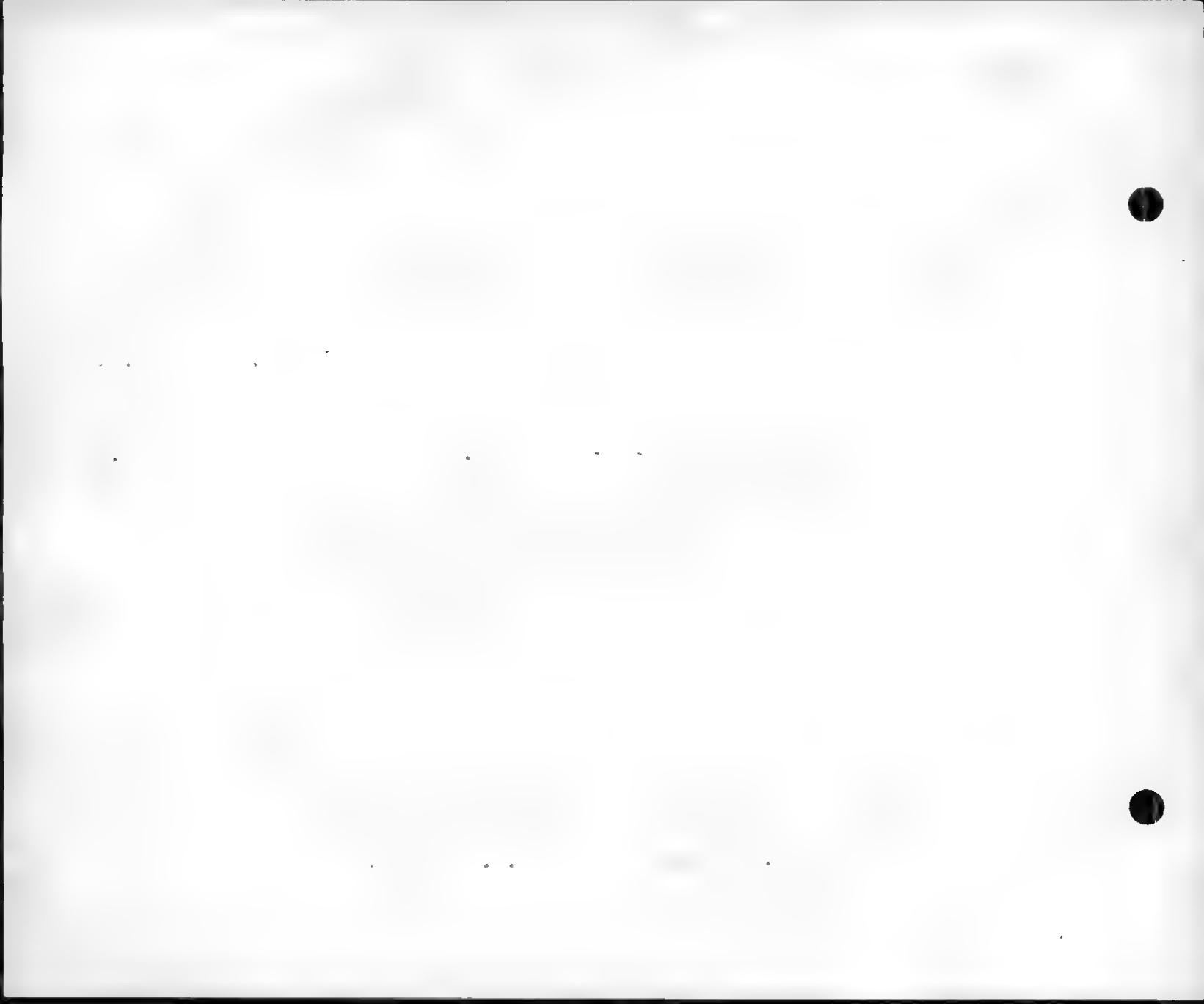
13002

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1299+

1. PLACE OF DEATH a. COUNTY <i>Albermarle</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairfax</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Easton Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles</i>	First <i>Charles</i>	Middle <i>Pinder</i>	4. DATE OF DEATH Month <i>Sept.</i> Day <i>21</i> Year <i>1967</i>
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>2/15/1902</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Various</i>	
13. FATHER'S NAME <i>Steve Pinder</i>		14. MOTHER'S MAIDEN NAME <i>Alice Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>213-24-1640</i>	
17. INFORMANT <i>Mrs. Mary Hines</i>		Address <i>Goldsboro, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Quanano D. Blader Grade III</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>C Metastases D Pelvic Recor</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>512 M</i>
20f. (City or town) <i>Easton</i>		(County) <i>Maryland</i>	
(State) <i>MD</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (1) (this hospital) attended the deceased from <i>9-13</i> , 19 <i>67</i> , to <i>9-21</i> , 19 <i>67</i> , that (1) (we) last saw the deceased alive on <i>9-21</i> , 19 <i>67</i> , and that death occurred at <i>512 M</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>9-22-67</i>	
22a. SIGNATURE <i>John N. Robinson</i>		22b. ATTENDING MEDICAL DIRECTOR M.D. PHYS. <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>John N. Robinson</i>		22d. ADDRESS <i>Easton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/24/1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Roseville Cemetery</i>
24. FUNERAL DIRECTOR <i>Kenneth Dally</i>		ADDRESS <i>Easton, Maryland</i>	25a. RECEIVED BY REGISTRAR <i>SEP 27 1967</i>
		DATE <i>1967</i>	25b. REGISTERED SIGNATURE <i>Judge</i>



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

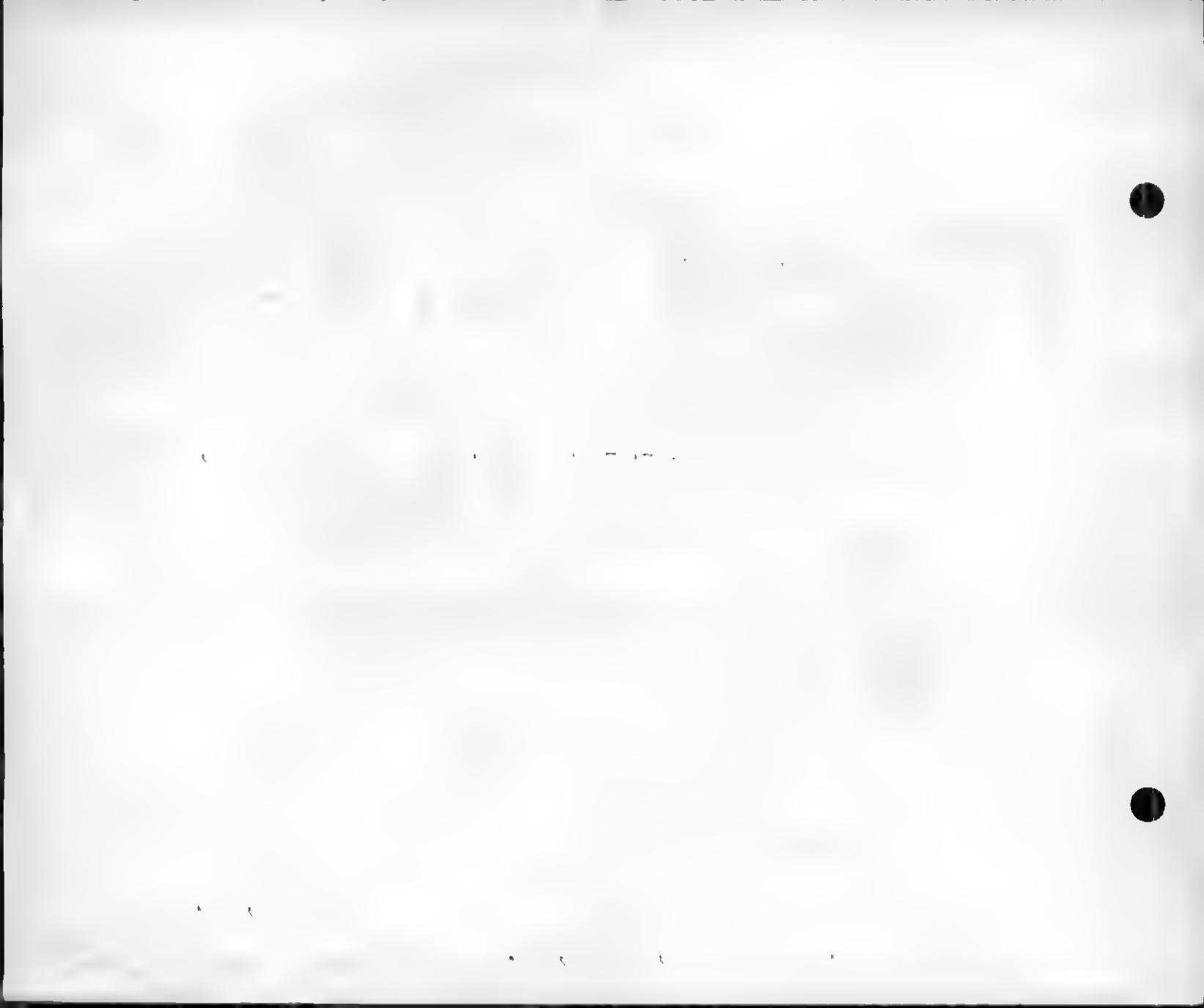
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in an event of removal, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13003

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SOMERSET	c. LENGTH OF STAY IN Tb 23 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Comfava	d. STREET ADDRESS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF Marquerite Milby (Type or print)	First	Middle	4. DATE OF DEATH Nov. 7. 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1896
9. AGE (In years lost to today) 70 yrs.	10. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (County & State, or foreign country) Queen Anne Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Franklin Milby	14. MOTHER'S MAIDEN NAME Mary Andrews		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 218-16-9015	17. INFORMANT Mrs. Jervis Cooke, Newark, Delaware	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Aug 13 1967	20f. (City or town) Easton (County) Md. (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 13 1967 , to May 1967 , that (I) (we) last saw the deceased alive on May 13 1967 , and that death occurred at Easton , M., from causes and on the date stated above.	22b. DATE SIGNED 9-9-67		
22a. SIGNATURE Kurt Ledderer	M.D. <input checked="" type="checkbox"/> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. PHYSICIAN'S NAME (Type) KURT LEDDERER	22d. ADDRESS QUEEN ANNE MD.
23a. BURIAL, CREMATION, REMAINS Burial	23b. DATE THEREOF 9/9/1967	23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill	23d. LOCATION (City or Town) Easton, Md. (County) Md. (State)
24. FUNERAL DIRECTOR MURICE E. NEUNAM & SON, Easton, Md.	ADDRESS	25a. REC'D. BY REGISTRAR DATE SEP 13 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12999

CERTIFICATE OF DEATH

13004

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

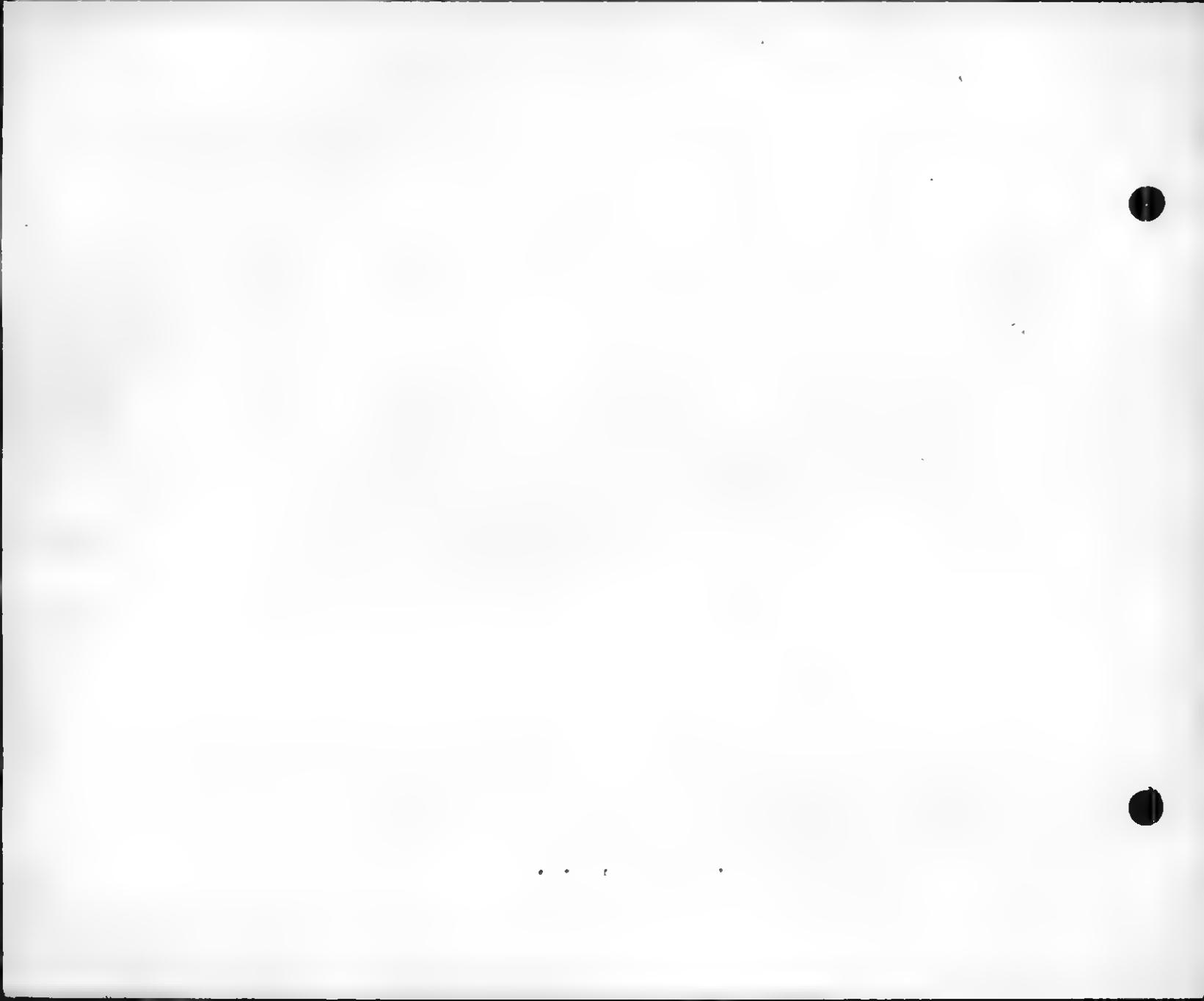
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Caston</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greensboro</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>		d. STREET ADDRESS <i>Sunset Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Aura</i>	First <i>Aura</i>	Middle <i>Marie</i>	Last <i>Shanahan</i>
4. DATE OF DEATH <i>9 26 1967</i>	Month <i>9</i>	Day <i>26</i>	Year <i>1967</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-30-1894</i>
9. AGE (In years at birthday) <i>72 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Penna.</i>	
13. FATHER'S NAME <i>Andrew Coyle</i>		14. MOTHER'S MAIDEN NAME <i>No Record</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>114-07-2751</i>	17. INFORMANT <i>Dorothy Shanahan</i>	Address <i>Greensboro, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i><24 hrs</i>	
Conditions, if any, which gave rise to immediate cause (a) (b) <i>None</i>			
stating the underlying cause (c) <i>None</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>None</i>		
20d. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>None</i> (County) <i>None</i> (State) <i>None</i>
21. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>9/26 1967</i> , and that death occurred at <i>7:00 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Trevor</i>		22b. DATE SIGNED <i>1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trevor</i>	22d. ADDRESS <i>None</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>9-30-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Greensboro</i>	23d. LOCATION (City or Town) <i>Greensboro</i> (County) <i>Caroline</i> (State) <i>Maryland</i>
24. FUNERAL DIRECTOR <i>J. E. Boulaire Greensboro, Md.</i>	25a. REC'D BY REGISTRAR <i>SEP 29 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
A15 (4) 25M 1/67			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event of removal, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items #2d & 9 File # 393 9/25/67 ph												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <i>Talbot</i> <i>Easton</i> <i>Maryland</i>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MD.</i> <i>Easton</i> <i>Graham Street</i>				13005				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN 1b				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hosp.</i>				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Nathan Slaughter</i>				4. DATE OF DEATH Sept. 17 Month Day Year 1967								
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>NEARO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>11-27-1901</i>	9. AGE (In years last birthday) <i>66</i> <i>65 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	11. IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Mill (grain)</i>				11. BIRTHPLACE (County & State or foreign country) <i>TALBOT - MD - USA</i>				12. CITIZEN OF WHAT COUNTRY? <i>NO</i>
13. FATHER'S NAME <i>NATHAN SLAUGHTER</i>				14. MOTHER'S MAIDEN NAME <i>MARY FRANCIS MURRAY</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO <i>219-01-07272</i>				17. INFORMANT <i>ROBERT SLAUGHTER - TAMPA, FL</i>				Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Uremia</i> <i>446 X</i>				19. INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>arteriolosclerous disease</i> DUE TO (c) <i>many years</i>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>pm</i> <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i>Easton, Maryland</i>				
20f. (City or town) <i>Easton</i> (County) <i>Md.</i> (State) <i>Maryland</i>												
21. I certify that (I) (this hospital) attended the deceased from <i>12 Sep 1967</i> to <i>17 Sep 1967</i> , that (I) (we) last saw the deceased alive on <i>9/17/67</i> , and that death occurred at <i>Easton, Maryland</i> , from causes and on the date stated above.												
22a. SIGNATURE <i>Stephen P. Carnery</i>				22b. DATE SIGNED <i>9-18-67</i>								
22c. PHYSICIAN'S NAME (Type) <i>Stephen P. Carnery, M.D.</i>				22d. ADDRESS <i>Easton, Maryland</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>9-21-67</i>				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Fairytown</i>				
23d. LOCATION (City or Town) <i>Easton, Maryland</i> (County) <i>Md.</i> (State) <i>Maryland</i>												
24. FUNERAL DIRECTOR <i>Barbara D.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 (4) 25M 1/67				DATE <i>SEP 20 1967</i>								

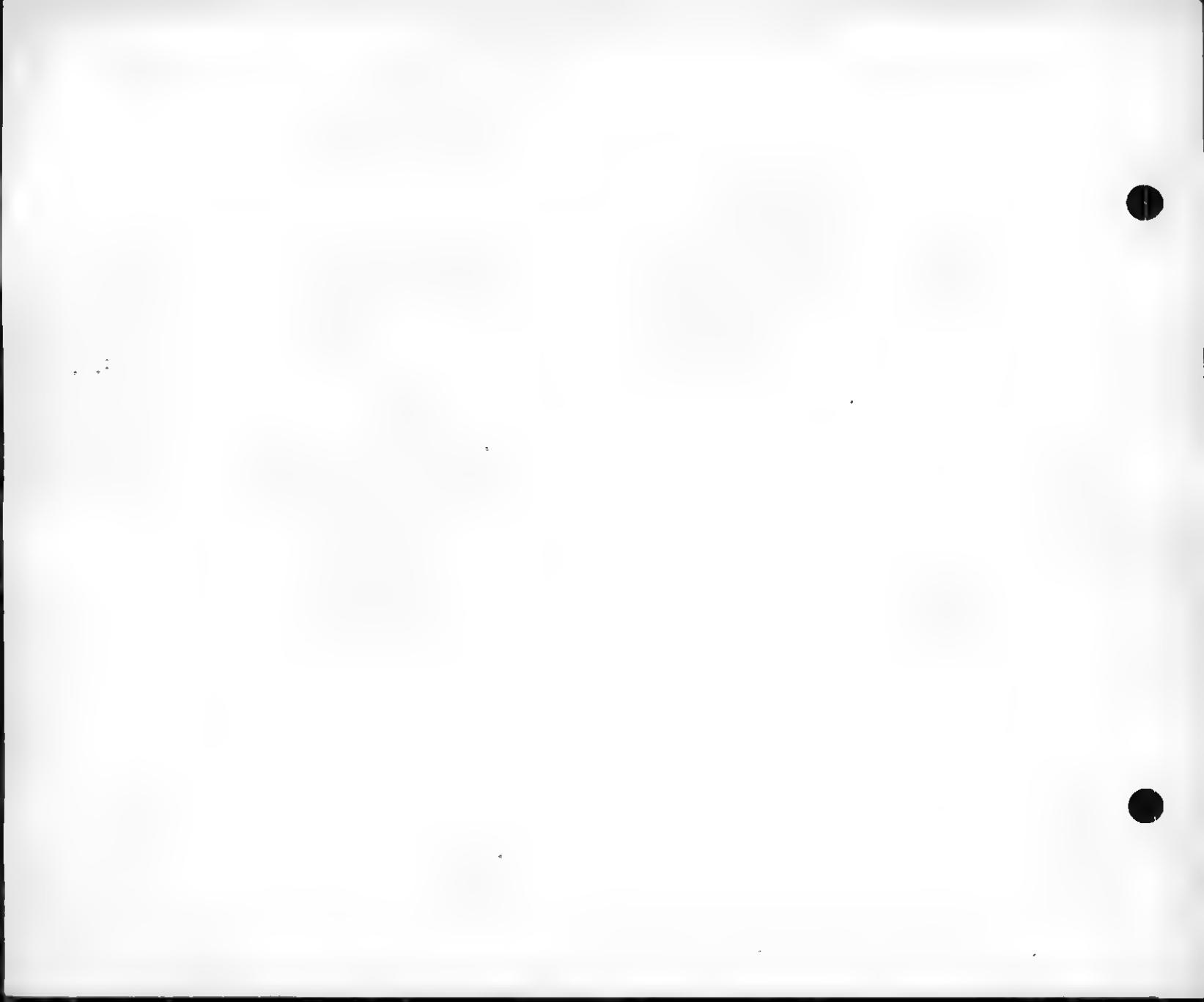


HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												CERTIFICATE OF DEATH			14514					
13001						Item #2 info, taken from birth cert. pg														
1. PLACE OF DEATH a. COUNTY <i>Albion</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>						c. LENGTH OF STAY IN lb 10 min						b. COUNTY Carol. ✓								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>						d. STREET ADDRESS 401 Central Avenue						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED FIRST <i>DABY</i> Middle <i>Girl</i> Last <i>Shoaf</i>						DATE OF DEATH 9 Month 8 Day 1967 Year														
4. SEX <i>F</i>	5. COLOR OR RACE white	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/67						9. AGE (In years last birthday) - yrs Months Days Hours Min 10										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State or foreign country) <i>Easton, Md. Memorial Hospital U.S.A.</i>						12. CITIZEN OF WHAT COUNTRY?								
13. FATHER'S NAME <i>Joseph A. Shoaf</i>						14. MOTHER'S MAIDEN NAME <i>Mary White</i>						Address								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO						17. INFORMANT <i>Mrs. Mary Shoaf Ridgley, Maryland</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Inhalation</i> DUE TO <i>Immature lung</i>												INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO <i>lungs</i> last (c) DUE TO <i>lungs</i>																				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour: o.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at <i>1122</i> M, from causes and on the date stated above.																				
22a. SIGNATURE <i>E.D. Hardy</i>						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22b. ADDRESS <i>1079/67</i>								
22c. PHYSICIAN'S NAME (Type) <i>E. D. Hardy</i>						M.D. ADDRESS <i>Easton, Maryland</i>						22d. LOCATION (City or Town) (County) (State) <i>Easton, Maryland</i>								
23a. BURIAL CREMATION OR INCINERATION <i>Incineration</i>						23b. DATE THEREOF <i>9/11/67</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Memorial Hospital</i>			23d. LOCATION (City or Town) (County) (State) <i>Easton, Maryland</i>								
24. FUNERAL DIRECTOR <i>Memorial Hospital, Easton, Maryland</i>						ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
												DATE <i>OCT 10 1967</i>								



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

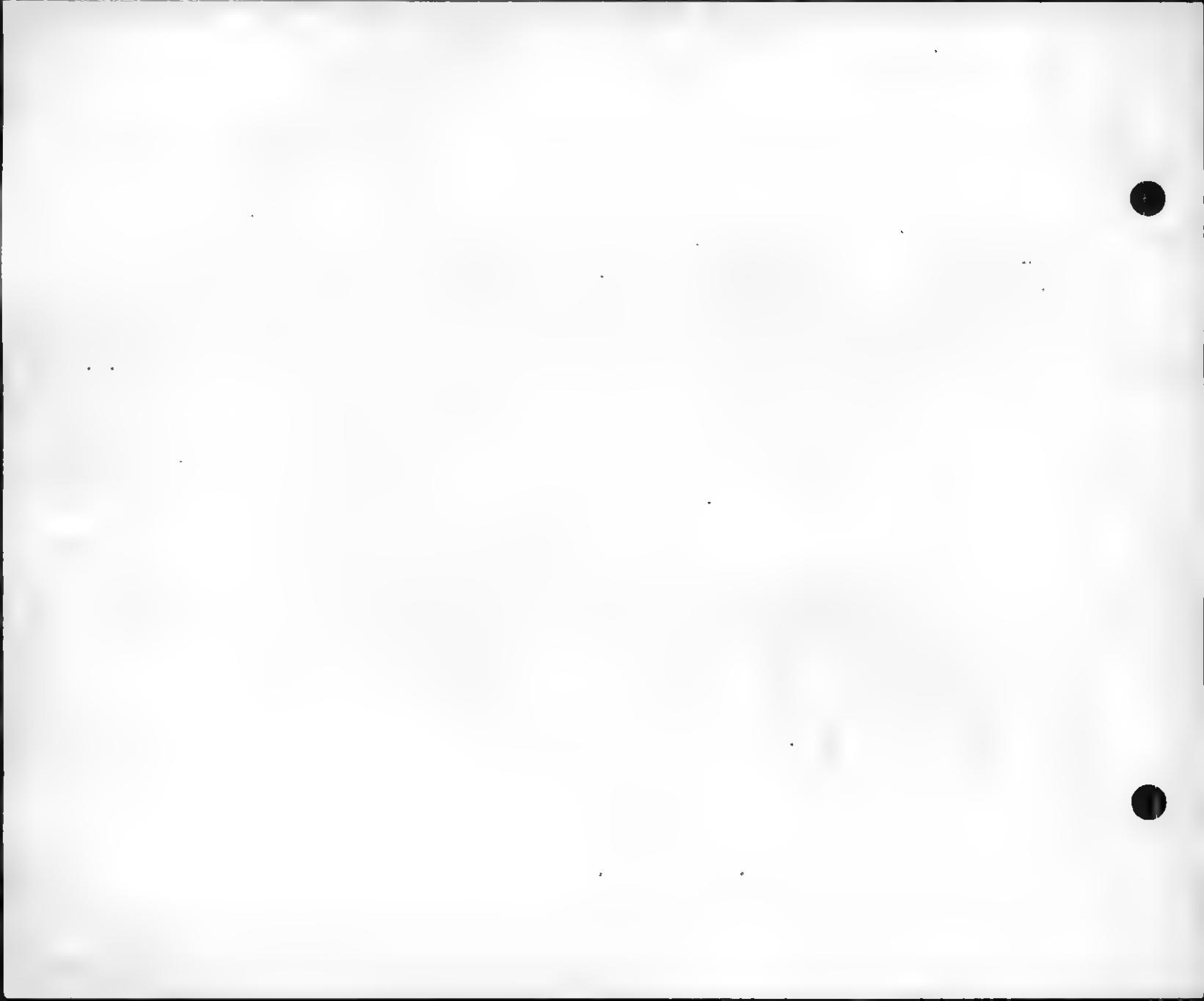
13006

13006

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Caroline ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frostn</i>		c. LENGTH OF STAY IN TB 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Preston</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>				d. STREET ADDRESS R.F.D. # 2 - POX 102		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>LEROY</i>		First <i>Lero</i>	Middle <i>White</i>	SPRINGS	Lost <i>Spring</i>	4. DATE OF DEATH Month <i>9</i>	Year <i>1967</i>
S. SEX <i>male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>February 16, 1936</i>	9. AGE (In years last birthday) <i>31</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Day Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Canning Factory</i>		11. BIRTHPLACE (State or foreign country) <i>Jacksonville, Florida</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Matthew White</i>				14. MOTHER'S MAIDEN NAME <i>Florida Mae Springs</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-32-8396</i>		17. INFORMANT <i>Florida Mae Ross, Preston, Md., RFD #2</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Irreversible Shock From External Hemorrhage</i> Onset and death hours 812 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Also possible internal hemorrhage</i> 6 hours DUE TO (c) <i>Compound Comminuted fracture humerus</i> 6 hours							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) ? Alcoholism							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Hit & run Route 318 between Preston & Federalsburg</i>					
20c. TIME OF INJURY Month Day Year Hour am <i>7 AM</i> pm <i>9/9/67</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <i>As above</i>		20f. (City or town) (County) (State) <i>Federalsburg Caroline Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Harold B. Plummer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Preston Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sent. 16, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Jonestown Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Near Preston, Maryland</i>	
24. FUNERAL DIRECTOR <i>Brampston Funeral Home Federalsburg Maryland</i>		ADDRESS 25a. REC'D BY REGISTRAR <i>SEP 18 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13003

Item # "b, c & d"

CERTIFICATE OF DEATH

13007

1. PLACE OF DEATH
a. COUNTY

Talbot

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Easton

3 yrs

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Home for Aged Women

3. NAME OF
DECEASED
(Type or print)

First

Middle

INA HIGGINS STANGE

4. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

B. DATE OF BIRTH

Oct 4, 1887

9. AGE (In years
last birthday)

Month

79 yrs

Day

12. CITIZEN OF WHAT COUNTRY?

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Nurse & Teacher

10b. KIND OF BUSINESS OR INDUSTRY

State Sanitarium

11. BIRTHPLACE (County & State, or foreign country)

St. Michaels, Maryland

USA

13. FATHER'S NAME

Daniel Higgins

14. MOTHER'S MAIDEN NAME

Henrietta Frampton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

212-32-4150

Albert B. Stange, 4501 Mainfield,

Address

Baltimore,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

33dx

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying

(b)

(a), stating the underlying
cause last.

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH
2 mrs.

MEDICAL CERTIFICATION

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED

(Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While Not While

at work at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from ... Sept. 11, 1967, to ... Sept. 11, 1967, that (I) (we) last saw the deceased alive on ... Sept. 11, 1967, and that death occurred at 3 PM, from the causes and on the date stated above.

22. SIGNATURE

Robert M. McDonald, M.D.

M.D.

ATTENDING PHYS.
MED. DIRECTOR
STAFF PHYS.

22c. PHYSICIAN'S
NAME (Type)

Robert M. McDonald, M.D.

22d. ADDRESS

9/11/67
DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Sept 14, 1967

23c. NAME OF CEMETERY OR CREMATORI

Parkwood Cemetery

23d. LOCATION (City, town or county)

(State)

Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

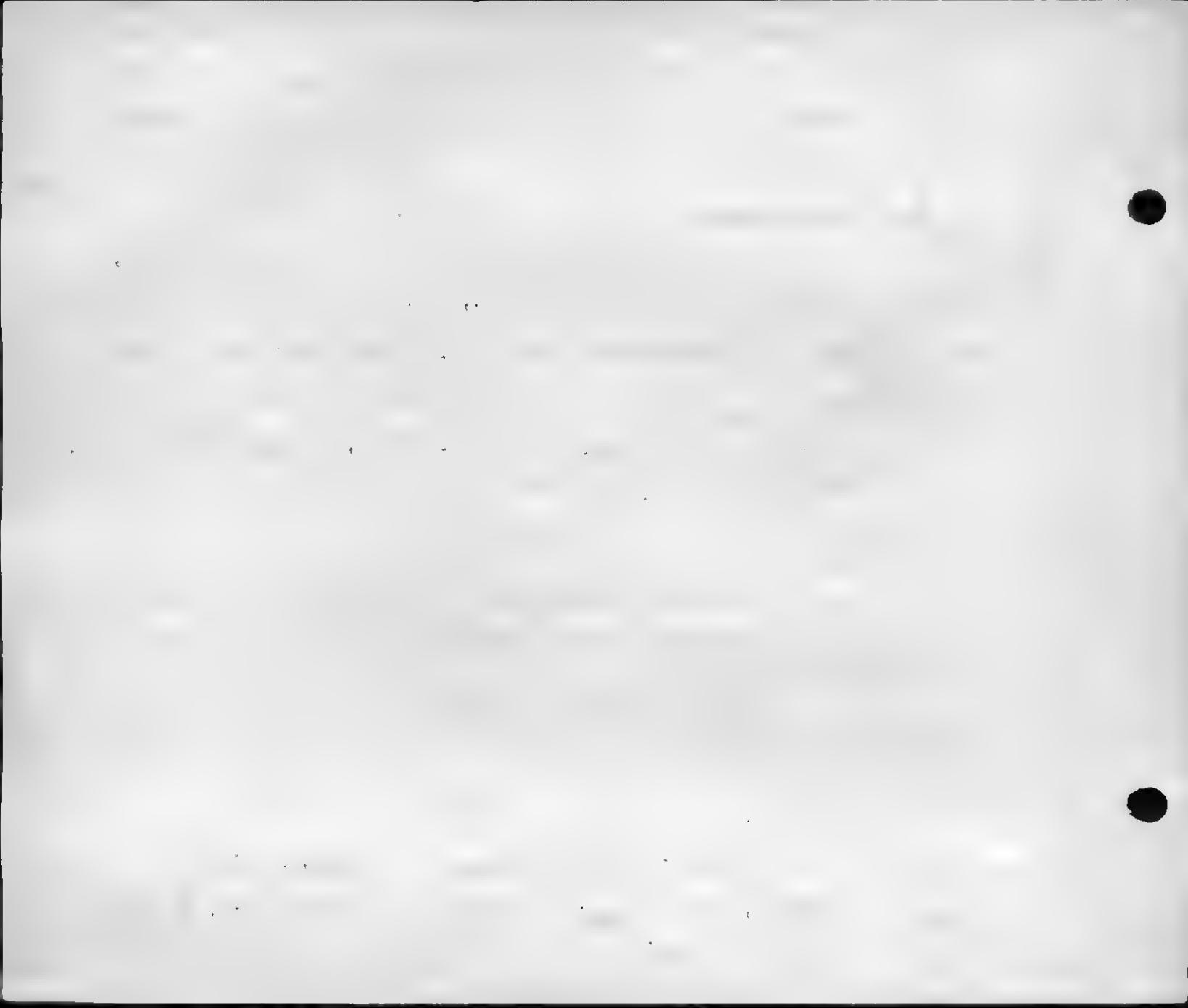
Harrison G. Leonard, St. Michaels, Md.

ADDRESS

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE SEP 18 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

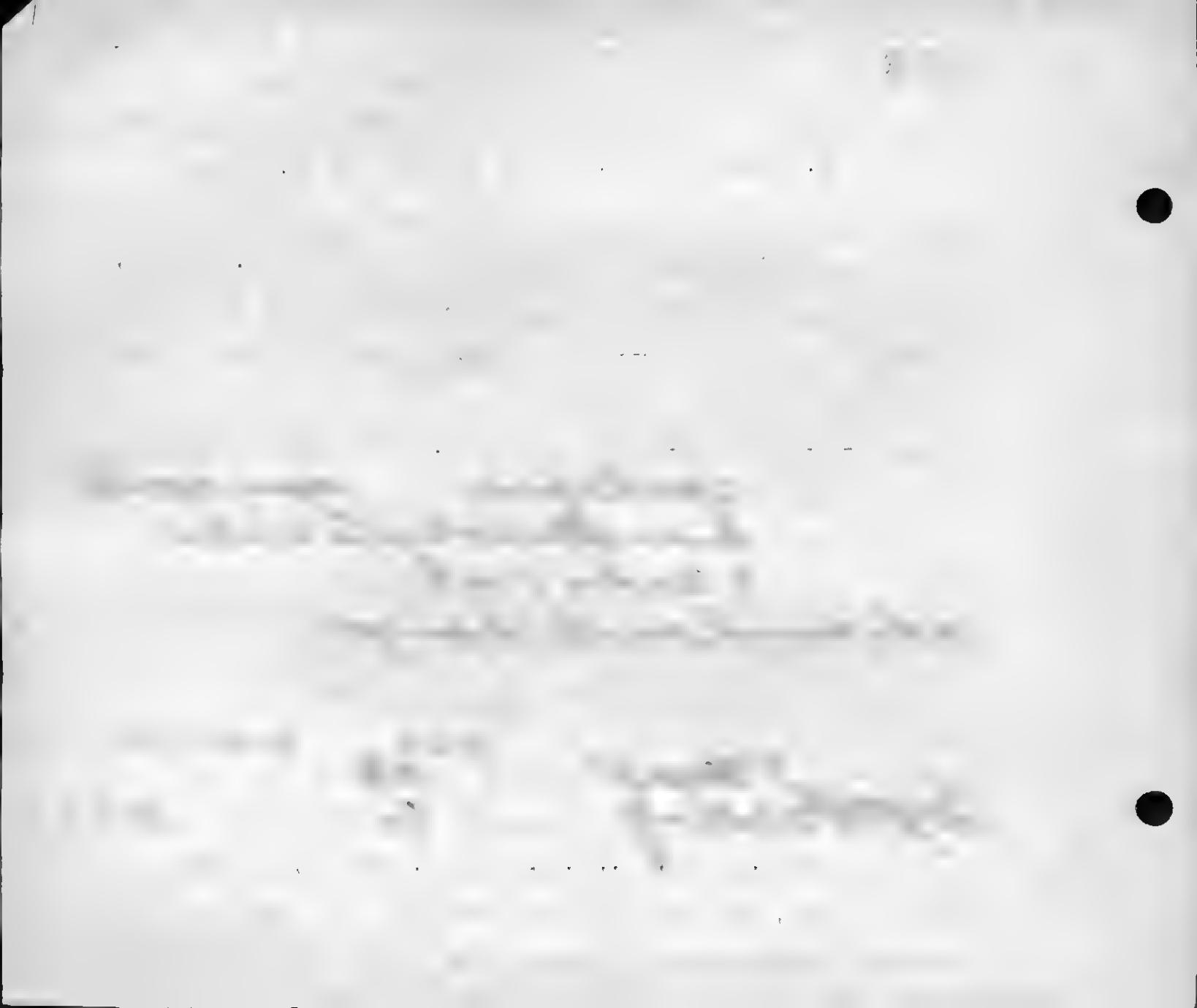
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14509 14519

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle JAMES	Last THOMAS
4. DATE OF DEATH	Month September	Day 30	Year 1967
5. SEX	6. COLOR OR RACE Male C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED X	8. DATE OF BIRTH Aug 18, 1870
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (County & State, or foreign country) St. Michaels, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Wilson Thomas	14. MOTHER'S MAIDEN NAME Mary ?	9. AGE (In years last birthday) 97 yrs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) No	16. SOCIAL SECURITY NO. 218-30-1190	17. INFORMANT William H. Thomas, St. Michaels, Maryland	Rt #1, Box 161 Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) cocklepid - many months DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) severe other seborrheic acne DUE TO (c) & cardiac vas d.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) advanced senile changes			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1953, 19, to 9-30-67, that (I) (we) last saw the deceased alive on 9-30-67, and that death occurred 10-4-67, from the causes and on the date stated above.		
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1953, 19, to 9-30-67 , that (I) (we) last saw the deceased alive on 9-30-67 , and that death occurred 10-4-67 , from the causes and on the date stated above.			
22c. PHYSICIAN'S NAME (Type) GUY M. REBSER Jr., M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS St. Michaels, Maryland	22b. DATE SIGNED 10-3-67
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 5, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Thomas Memorial Cemetery	23d. LOCATION (City, town or county) (State) St. Michaels, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Harrison E. Leonard, St. Michaels, Md	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 3 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

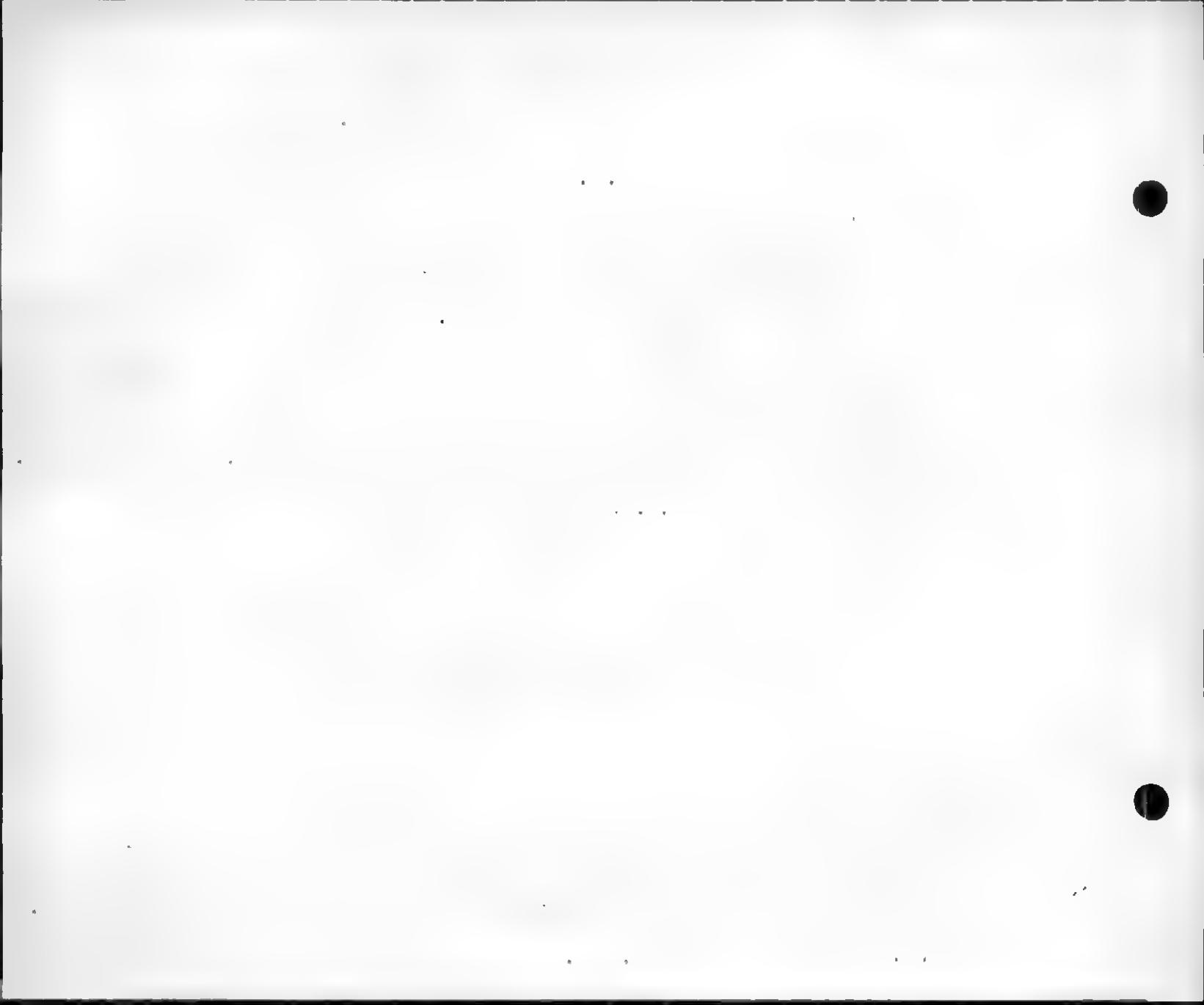


**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #7 File #G393 9/27/67 ph MEDICAL EXAMINER'S CERTIFICATE OF DEATH												13008					
1 PLACE OF DEATH a COUNTY Talbot MARYLAND						2 USUAL RESIDENCE [Where deceased lived, if institution Residence before admission] a STATE Md. b COUNTY Talbot											
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			c LENGTH OF STAY IN lb D.O.A			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDaniel			d STREET ADDRESS			e S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial																	
3 NAME OF DECEASED (Type or print)		First Earl		Middle Samuel		Last Turner		4 DATE OF DEATH Sept 16 1967		Month		Doy 1667		Year 1967			
5 SEX Male		6 COLOR OR RACE Negro		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8 DATE OF BIRTH Nov. 7, 1929		9 AGE (In years last birthday) 37 yrs		IF UNDER 1 YEAR Months		F UNDER 24 HRS Days Hours Min					
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY USA											
13. FATHER'S NAME Theophilius Murray						14. MOTHER'S MAIDEN NAME Catherine Turner						Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO 220-26-3989		17. INFORMANT Leonard Palmer		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) G.S.W. Chest 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH									
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) shot during altercation in bar															
20c TIME OF INJURY Month, Day, Year Hour 11:30 pm 9-16 1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) bar		20f CITY OR TOWN St Michaels		(County) Talbot		(State) Md.							
21. I certify that I took charge of the remains described above, had an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22. DATE SIGNED 9-19-67					
ACTUAL SIGNATURE <i>Louis J. Welty</i>		EXAMINER'S NAME (Type) Welty		CHIEF MEDICAL EXAMINER MD for ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town or county) Claiborne		23d LOCATION (City or Town) Claiborne		(County) Talbot		(State) Md.					
23a BURIAL CREMATION, BURIAL <input checked="" type="checkbox"/>		23b DATE THEREOF 9-22-67		23c NAME OF CEMETERY OR CREMATORIAL Claiborne				23d LOCATION (City or Town) Claiborne		(County) Talbot		(State) Md.					
24 FUNERAL DIRECTOR B.L. Dashiell		ADDRESS Easton, Md.		25a REC'D BY REGISTRAR DATE SEP 20 1967		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

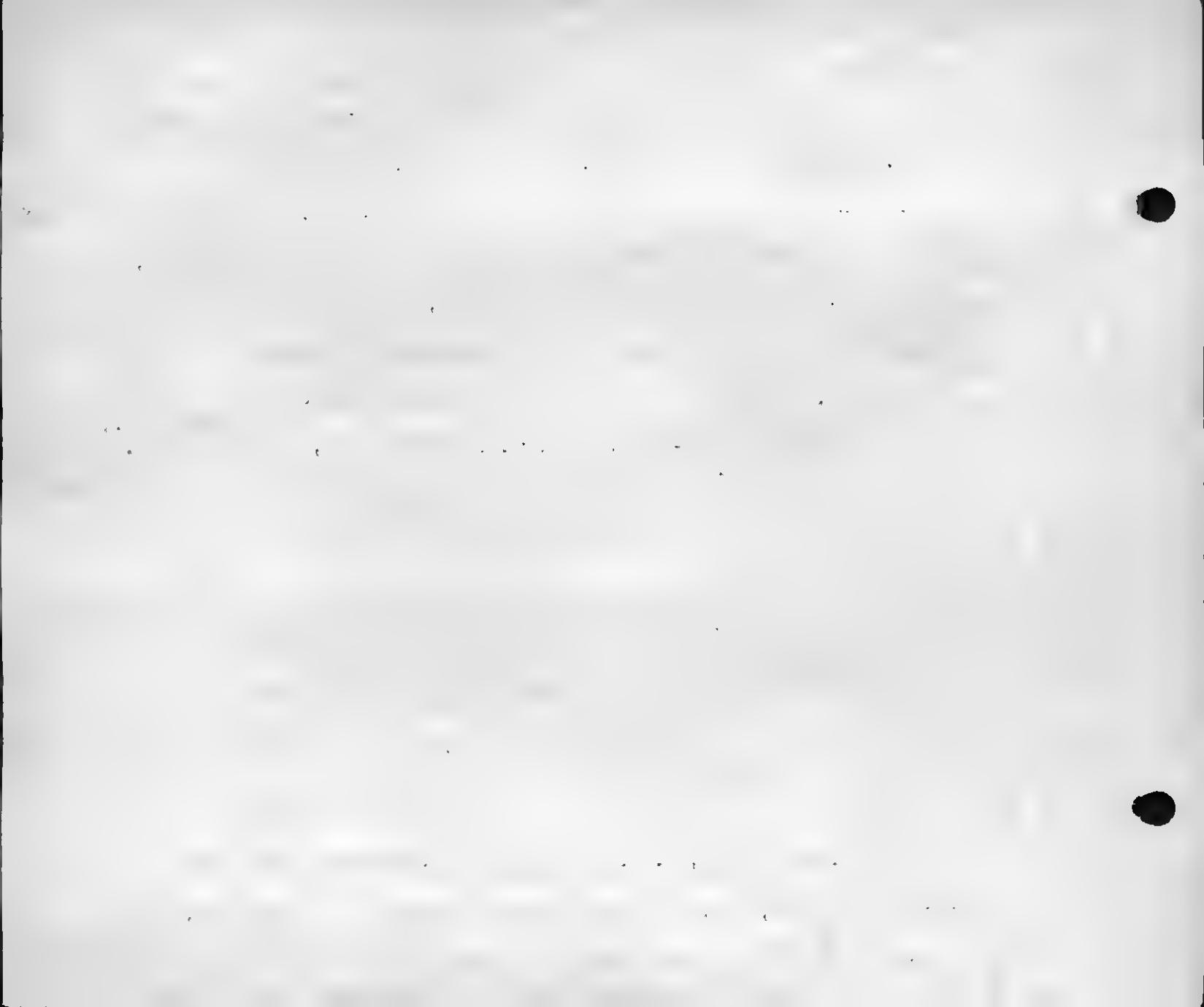
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13005 Item#1d Film #G395 10/2/87 pg 13009
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md.</i>	b. COUNTY <i>Dor.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	c. LENGTH OF STAY IN 1b <i>2 mo.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Herrick</i>	d. STREET ADDRESS <i>Main</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>520 N. Washington St.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Maudie Ellis Venables</i>	First <i>Maudie</i>	Middle <i>Ellis</i>	Last <i>Venables</i>	4. DATE OF DEATH Month <i>9</i> Day <i>18</i> Year <i>1967</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/2/1896</i>	9. AGE (In years last birthday) IF UNDER 1 YEAR yrs. <i>71</i> Months <i>11</i> Days <i>18</i> Hours <i>10</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Owned & operated a Rest Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Industry</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Delaware</i>
13. FATHER'S NAME <i>Jacob Ellis</i>		14. MOTHER'S MAIDEN NAME <i>Lizzie Spear</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Lloyd Christopher, Easton, Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10 mos</i>
112X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		DUE TO (b) <i>Carcinoma of the endometrium</i>		3 yrs
		DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized Arteriosclerosis enlarged varicosities both legs</i>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>10-14</i> , 19 <i>53</i> , to <i>9-18</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9/16/67</i> , and that death occurred at <i>SA</i> M, from the causes and on the date stated above.				
22a. SIGNATURE <i>Steiner</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>9-19-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Harold B. Plummer M.D.</i>		22d. ADDRESS <i>Preston Md.</i>		

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>9/20/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Firemen's</i>	23d. LOCATION (City, town or county) (State) <i>Sharptown, Md</i>
24. FUNERAL DIRECTOR <i>Beth S. Hollingsby, East New Market Md</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>SEP 25 1967</i>	25b. REGISTRAR'S SIGNATURE <i>John J. O'Brien</i>





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH						13011									
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>			b. COUNTY <i>TALBOT</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>			c. LENGTH OF STAY IN lb <i>2hr 10min</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ST. MICHAELS</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>EVA</i>			First <i>Mac</i>	Middle <i></i>	Last <i>Willey</i>	4. DATE OF DEATH Month <i>9</i>	Day <i>12</i>	Year <i>1967</i>	5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 1, 1897</i>	9. AGE (in years last birthday) <i>69 yrs</i>	10. IF UNDER 1 YEAR <i>Months</i>	11. IF UNDER 24 HRS <i>Days Hours Min.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>			11. BIRTHPLACE (County & State or foreign country) <i>PARKTON, MD</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>						
13. FATHER'S NAME <i>HARRY ENSOR</i>			14. MOTHER'S MAIDEN NAME <i>JENNY ELIZABETH HECK</i>			Address <i>EDWARD WILLEY, ST. MICHAELS, MD</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO <i>2A-09-0300</i>			17. INFORMANT <i>EDWARD WILLEY, ST. MICHAELS, MD</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Cerebral vascular</i> DUE TO <i>194</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause first <i>small cell carcinoma of lung, brain</i> (b) <i></i> DUE TO <i></i> (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			20c. TIME OF INJURY Month Day, Year Hour o.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>St. Michaels</i> (County) <i>St. Michaels</i> (State) <i>MD</i>				
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 1967</i> , to <i>Sept 12 1967</i> , that (I) (we) last saw the deceased alive on <i>17 Sept 1967</i> , and that death occurred at <i>94 M</i> , from causes and on the date stated above.									22b. DATE SIGNED <i>9-13-67</i>						
22a. SIGNATURE <i>R. Lane Wroth</i>			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22d. ADDRESS <i>St. Michaels, Maryland</i>									
22c. PHYSICIAN'S NAME (Type) <i>R. Lane Wroth</i>			M.D.			23d. LOCATION (City or Town) <i>St. Michaels, Md.</i> (County) <i>St. Michaels</i> (State) <i>MD</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>SEPT 15, 1967</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Olivet Cemetery</i>			23d. LOCATION (City or Town) <i>St. Michaels, Md.</i> (County) <i>St. Michaels</i> (State) <i>MD</i>						
24. FUNERAL DIRECTOR <i>Harrison Leonard, St. Michaels</i>			ADDRESS			25a. REC'D BY REGISTRAR <i>SEP 18 1967</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



X
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13008

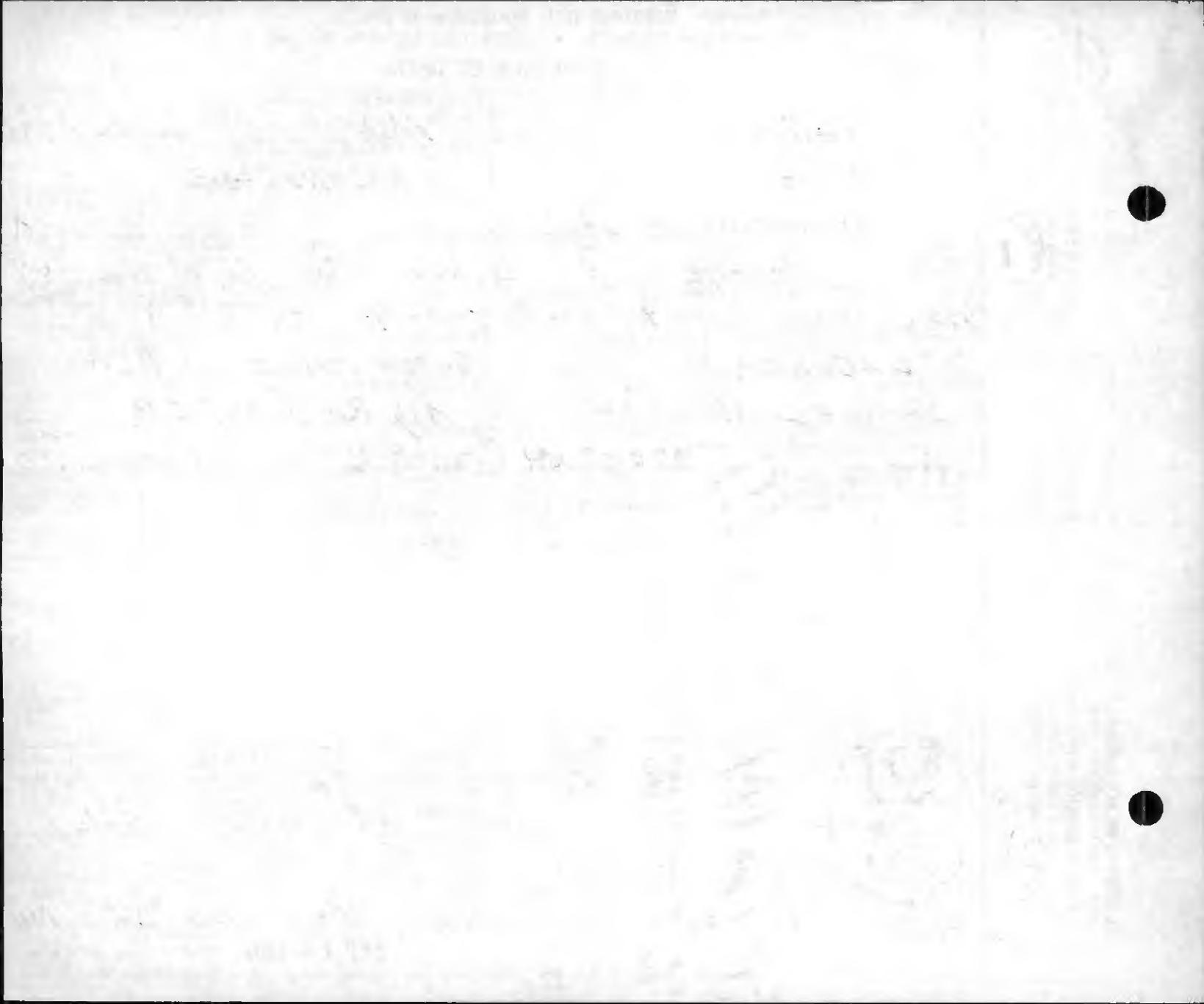
CERTIFICATE OF DEATH

13012

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>QUEEN ANNE</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>78</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>		d. STREET ADDRESS <i>GRASONVILLE</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17		
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>H</i>	Last <i>Wilson</i>	
4. DATE OF DEATH Month <i>Sept.</i>	Day <i>12</i>	Year <i>1967</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-11-90</i>	
9. AGE (In years last birthday) yrs. <i>97</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>	11. BIRTHPLACE (County & State, or foreign country) <i>QUEEN ANNE</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>SAMUEL Wilson</i>	14. MOTHER'S MAIDEN NAME <i>MYRA CARTER</i>	Address <i>112 GEORGE Wilson, Jr. - GRASONVILLE</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>	16. SOCIAL SECURITY NO. <i>220-07-0021</i>	17. INFORMANT <i>GEORGE Wilson, Jr. - GRASONVILLE</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Armenia</i> 446 X DUE TO (b) <i>Atherosclerotic nephropathy</i> (?) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) stating the underlying cause (c) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>29 Aug. 1967</i> , to <i>12 Sept. 1967</i> that (I) (we) last saw the deceased alive on <i>12 Sept. 1967</i> , and that death occurred at <i>7 PM</i> , from causes and on the date stated above.				
22a. SIGNATURE <i>Thurston Harrison</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>14 Sept 1967</i>
22c. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>	22d. ADDRESS <i>Easton, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>9-16-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>GRASONVILLE</i>	23d. LOCATION (City or Town) (County) (State) <i>GRASONVILLE - QUEEN ANNE MR</i>	
24. FUNERAL DIRECTOR <i>Dashiel Funeral Home</i>	ADDRESS	25a. REC'D. BY REGISTRAR DATE <i>SEP 15 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13009

CERTIFICATE OF DEATH

13013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Q.H.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centerville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS RFD #1 Box 23			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First LIDA	Middle m	Last WRIGHT		
4. DATE OF DEATH	Month 9	Day 10	Year 1967		
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-15-11		
9. AGE (In years, lost birthday) 56 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	11. KIND OF BUSINESS OR INDUSTRY —	12. BIRTHPLACE (County & State, or foreign country) Maryland		
13. FATHER'S NAME WILLIAM DAWKINS	14. MOTHER'S MAIDEN NAME LUCY MACKABLE	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO.	17. INFORMANT MRS. WALTER O'HALL, CRNTREVILLE MD.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) of the cervix DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Uncertain		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) —	(County) —	(State) —
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 540 M. , from causes and on the date stated above.					
22a. SIGNATURE Robert W. Trever M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/11/67		
22c. PHYSICIAN'S NAME (Type) Robert W. Trever M.D.		22d. ADDRESS Easton, Maryland	23d. LOCATION (City or Town) (County) (State) BRIDGEVILLE DEL.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF SEPT. 13, 1967	23c. NAME OF CEMETERY OR CREMATORIUM BRIDGETON	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Charles J. Moore Denton And	ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 25M 1/67		DATE SEP 14 1967			

